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1 UNITED STATES DISTRICT COURT
2 SOUTHERN DISTRICT OF NEW YORK

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3 M.D. DANIEL CAMERON,

4 Plaintiff,

New York, N.Y.

5 v.

17 Civ. 3420 (JGK)

6 M.D. HOWARD ZUCKER, in his
7 official capacity as
8 Commissioner of New York State
9 Department of Health, et al.,

Defendants.

-----x

10 June 6, 2017

11 9:40 a.m.

12 Before:

13 HON. JOHN G. KOELTL,

14 District Judge

15
16 APPEARANCES

17 JACQUES G. SIMON
18 Attorney for Plaintiff

19 ERIC T. SCHNEIDERMAN
20 Attorney General of the State of New York
21 BY: JAMES M. HERSHLER
22 TODD A. SPIEGELMAN
23 Assistant Attorneys General

24 ALSO PRESENT:

25 HENRY S. WEINTRAUB,
Chief Counsel
N.Y. State Department of Health

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1 (Case called)

2 MR. SIMON: Jacques Simon representing Dr. Cameron.

3 THE COURT: Good morning.

4 MR. SIMON: And this is Dr. Cameron sitting with me.

5 MR. HERSHLER: James Hershler, representing the
6 defendants.

7 MR. SPIEGELMAN: Todd Speigelman, also for the
8 defendants.

9 MR. WEINTRAUB: Henry Weintraub representing the
10 Department of Health.

11 THE COURT: Okay. I don't have your appearance.

12 MR. WEINTRAUB: I'm not going to be participating. I
13 am here really in my role as a client, not as an attorney *per*
14 *se*.

15 THE COURT: Okay. And your name is?

16 MR. WEINTRAUB: Henry Weintraub, W-E-I-N-T-R-A-U-B.

17 THE COURT: Thank you.

18 This is a motion for a preliminary injunction. I
19 received all of your correspondence. I received the
20 plaintiff's additional submissions, which I have accepted. I
21 received the defendants' request to add Dr. Meyers, which was
22 agreed to. The correspondence indicated that the parties
23 wanted me to receive in evidence all of the essentially
24 exhibits that have been submitted in connection with the motion
25 for preliminary injunction, and also to treat the prior

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1 affidavits that were submitted by Dr. Cameron and by
2 Mr. Nemerson as affidavits in lieu of direct testimony.

3 Of course I can consider on this motion for
4 preliminary injunction all of the papers that you have
5 submitted, including the affidavits that have previously been
6 submitted and all of the exhibits that you previously have
7 submitted, I will take all of those in connection with the
8 motion for preliminary injunction.

9 The reason for the hearing today was to allow you to
10 make any arguments and present any evidence that you wanted to
11 that you thought should be presented in live testimony, so you
12 are welcome to present anything you want in live testimony from
13 any of the witnesses, whether it is in addition to or
14 duplicates, anything that is in the affidavits, in support of
15 the motion for a preliminary injunction or in opposition to the
16 motion.

17 I am familiar with the papers. I will listen to any
18 opening statements, and then I will listen to any evidence that
19 the parties wish to present.

20 I had indicated an hour for each side, which would be
21 only for your direct and redirect, not for any time that you
22 use in cross-examining the other party, so there is more than
23 enough time for you. I wanted to give you some guidance with
24 respect to a reasonable time for the hearing, particularly
25 since you have submitted extensive affidavits and I have read

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1 the affidavits, and I will certainly consider those affidavits.

2 What you see going on now is an attempt to give me
3 realtime reporting, which I usually have in the course of any
4 evidentiary hearing.

5 So, with all of that, Mr. Simon.

6 MR. SIMON: Good morning, your Honor.

7 Apparently in my zest to simplify matters, I
8 complicated them, because I did everything electronically.
9 Last night, before the day was over, I talked to the attorney
10 for the defendants, and we reached a stipulation that we put in
11 writing. And, towards that, what I did to simplify things even
12 further, rather than coming up with boxes and boxes of paper, I
13 did a plaintiff's list of exhibits, of stipulated exhibits, and
14 I put it on USB for your Honor. I gave it to the state
15 attorney.

16 We would like to simplify matters by moving the
17 exhibits on plaintiff's exhibit list into evidence. Some of
18 them, as I said, are already part of the court file. I marked
19 them in an abundance of caution. I marked them by reference
20 into the list of exhibits. The only new exhibits that we
21 have --

22 THE COURT: Are the medical files.

23 MR. SIMON: -- are the medical files, Dr. Cameron's
24 CV, and the two exhibits that the defendants have that I
25 understand I have no objection to is Mr. Nemerson affirmation

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1 that you already have in the court file and Dr. Meyers' CV
2 which I did not object to.

3 So, with that in mind, if I can pass this on to the
4 court, this is a complete list of exhibits.

5 THE COURT: Okay.

6 MR. SIMON: So I move all of those exhibits into
7 evidence as stipulated for the defendants, and there is no
8 objection to them.

9 THE COURT: Yes, right. The plaintiff's list of
10 exhibits that you have already described are admitted in
11 evidence and two defendants exhibits, which I take it are
12 Defendants' Exhibit 1 and 2. Defendants' Exhibit 1 is?

13 MR. SIMON: Mr. Nemerson's affirmation, I believe,
14 with various exhibits attached.

15 THE COURT: And 2 is Meyers' affidavit?

16 MR. SIMON: No, Meyers' CV. Dr. Meyers is testifying
17 live. I have heard and, again, I tried to simplify. I was
18 very mindful of your Honor's order, and I saw everything -- the
19 court was working hard during the Memorial Day weekend. I was
20 really mindful of the time that you allotted, and I didn't want
21 to encroach on that. And I brought Dr. Cameron initially here
22 because I didn't know how the new submissions were going to
23 come out until the last moment last night, but I didn't really
24 want to take the court's time with repeating what is in the
25 affidavits unless your Honor wants to hear a little bit about

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1 Dr. Cameron's background, who he is, and the differences
2 between IDSA and ILADS, which I already put in the affidavit.
3 So I was trying to be very, very mindful and conservative with
4 the court's time, because I know the court's time is precious.

5 THE COURT: Well, that is fine. Whatever you want to
6 do is fine. So whatever you want Dr. Cameron to testify to is
7 fine.

8 MR. SIMON: I think the way I envisioned it and I
9 shared it with the defense counsel and I want to share it with
10 the court, is because Dr. Cameron said everything he had to say
11 in the affidavits, I am going to reserve him for rebuttal,
12 because I understand they are going to put Dr. Meyers on and
13 they may put Mr. Nemerson on. So what Dr. Cameron will have to
14 say is in rebuttal to what the defense is going to say, because
15 pretty much everything was said in his affidavit, and the
16 exhibits are there.

17 THE COURT: Okay.

18 MR. SIMON: Unless will you want to hear a little bit
19 about...

20 THE COURT: Whatever you want Dr. Cameron to testify
21 to is really up to you. So if you don't want to put
22 Dr. Cameron on and you want to wait for the defendants to put
23 Mr. Nemerson on and Dr. Meyers, that's fine, and put
24 Dr. Cameron on in rebuttal, that's fine.

25 As you have said, there is a lengthy affidavit from

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1 Dr. Cameron, a lengthy affidavit from Mr. Nemerson. Originally
2 the defendants said they may not put Mr. Nemerson on because he
3 said what he wanted to say in his affidavit, but they might
4 want to put him on, and then they asked to put Dr. Meyers on.
5 So whatever the parties want to do in terms of putting on
6 evidence.

7 So Mr. Simon?

8 MR. SIMON: At this point I think I am going to
9 rely -- for the initial case, I am going to rely on what
10 Dr. Cameron said in the affidavit, and I think that's a
11 judicious time expenditure.

12 THE COURT: Okay.

13 MR. SIMON: And then I am going to bring him up on
14 rebuttal.

15 THE COURT: Okay.

16 So then the next question is whether the defendants
17 want to cross-examine Dr. Cameron on anything that's in his
18 affidavit, right?

19 MR. HERSHLER: Thank you, your Honor.

20 There are some issues that we would like to
21 cross-examine him on. However, for two reasons, if it's all
22 right with everyone, we would reserve that until he is put on
23 in rebuttal.

24 THE COURT: Fine. Sure.

25 MR. HERSHLER: The reason is --

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1 THE COURT: So is there any other live testimony,
2 Mr. Simon, that you want to put on?

3 MR. SIMON: No. I think we said plenty in the
4 affidavits, like your Honor said, and I think that this is a
5 pretty good plan that the Attorney General said.

6 THE COURT: Okay. So then I will turn to the
7 defendants and ask what live testimony you would like to put
8 on.

9 MR. HERSHLER: Thank you, your Honor.
10 We would like to call Dr. Burt Meyers first and, after
11 him, Mr. Nemerson.

12 THE COURT: Okay. Is Mr. Nemerson in court? Yes. He
13 is raising his hand. If he is going to be a witness, shouldn't
14 he leave the court?

15 MR. SIMON: Your Honor, I am going to request actually
16 that he does. He is not a party to this action. He is a
17 nonparty.

18 THE COURT: So he will go to the witness room. Thank
19 you.

20 Mr. Fletcher will show you the witness room.

21 If Dr. Meyers will take the stand.

22 BURT MEYERS,

23 called as a witness by the defendants,

24 having been duly sworn, testified as follows:

25 THE COURT: Dr. Meyers, please keep your voice up.

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Meyers - Direct

1 Mr. Hershler, you may examine.

2 MR. HERSHLER: Thank you, your Honor.

3 DIRECT EXAMINATION

4 BY MR. HERSHLER:

5 Q. Dr. Meyers, your curriculum vitae is already in the record,
6 so I am not going to belabor your credentials and background.

7 MR. HERSHLER: Does everyone have a copy of his CV?

8 MR. SIMON: I'm not sure the judge does, because I
9 didn't --

10 THE COURT: Okay, I have a copy of Dr. Meyers' CV
11 which is admitted in evidence as Defense Exhibit 2. Okay.

12 MR. HERSHLER: Thank you.

13 BY MR. HERSHLER:

14 Q. I am going to try to cut to the chase as much as possible.

15 Dr. Meyers, could you just briefly summarize your
16 background, particularly your qualifications in the area of
17 infectious disease?

18 A. So, after medical school, I took an internal medicine
19 residency; and then a fellowship in infectious diseases; and
20 then served in the Air Force; then went to Mt. Sinai, where I
21 was a resident; and then 35 years in the division of infectious
22 disease; rose to be a professor of medicine, and started a
23 section called -- and I became the director of transplantation
24 infectious diseases. Most of the patients I saw were
25 inpatients in the hospital, critically ill. I didn't really

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Meyers - Direct

1 have an office practice.

2 Q. When did you last actually treat patients?

3 A. I left Mt. Sinai in 2004.

4 Q. And currently what do you do?

5 A. I am a contract worker, consultant for the New York State
6 Department of Health in OPMC.

7 Q. Have you ever treated patients suffering from Lyme disease?

8 A. Not at any office setting. In a hospital setting possibly
9 as part of a differential diagnosis I may have been involved,
10 but I never personally took care of somebody, you know, because
11 most of those patients are outpatients with Lyme disease.

12 Q. Back in 2010 and 2011, what was your position with the
13 Department of Health?

14 A. I was a medical -- or and am a medical coordinator.

15 Q. What does that position involve?

16 A. What we do is basically review -- well, let me backtrack.
17 Complaints come in, I guess, up to Albany, and then they come
18 down to us, where a patient or the commissioner of health may
19 decide that something should be investigated. So I am one of
20 the physicians who investigates. And since my field is
21 infectious disease, most of the cases that I see and review are
22 infectious disease cases.

23 Q. Were you involved at all in the investigation of
24 Dr. Cameron?

25 A. Yes.

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Meyers - Direct

1 Q. In what capacity?

2 A. So, I reviewed many of the charts, and then actually had an
3 interview or two interviews with Dr. Cameron.

4 Q. What was the purpose of those interviews?

5 A. The reason for the interview is to give the doctor a chance
6 to explain what and how he took care of a patient or patients.
7 It was his chance to tell his story. That's what we tell them
8 when they come in.

9 Q. Is that what happened in the case of Dr. Cameron?

10 A. Yes.

11 THE COURT: What were the years when those two
12 interviews occurred?

13 THE WITNESS: I think they were 2011. I have to look.

14 THE COURT: Okay.

15 THE WITNESS: I think they both were 2011.

16 MR. HERSHLER: Let the record reflect that I did share
17 a copy of what was originally Exhibit F for plaintiff to
18 Dr. Meyers in preparation for his testimony; and Exhibit F
19 includes, among other things, Dr. Cameron's affidavit and the
20 reports of the interview that was conducted of him by the
21 Office of Professional Medical Conduct, as well as his response
22 to the report of the interview.

23 Q. Is that correct, Dr. Meyers?

24 A. No, I think it was 2010.

25 Q. Have you reviewed -- have you had the chance to review

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Meyers - Direct

1 Exhibit F?

2 A. Yes.

3 THE COURT: Dr. Meyers, are you reading something?

4 THE WITNESS: No, no, I'm trying to see what the dates
5 of the interview are.

6 THE COURT: I know, but you should testify from your
7 own recollection.

8 THE WITNESS: Yeah. Well, I said I thought --

9 THE COURT: Hold on. Put aside anything, all right?
10 Don't look at anything for purposes of your testimony. If you
11 have got something on the witness stand, turn it over. Tell us
12 what your recollection is.

13 If you need something to refresh your recollection,
14 say that it would be useful to refer to something to refresh
15 your recollection. Okay?

16 THE WITNESS: Okay, sure.

17 THE COURT: Okay.

18 BY MR. HERSHLER:

19 Q. Can you briefly describe how the interview progressed? How
20 did it --

21 A. There were a bunch of cases, and I would ask -- Dr. Cameron
22 and I would have the record, and I would ask a question about,
23 Did you examine this patient? did you do this? did you do that?
24 What was your plan of action? etc. And we had a dialogue, he
25 and I, over at least these ten or eleven patients, over these

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Meyers - Direct

1 two different interview dates.

2 Q. I see.

3 Was someone recording what was said during --

4 A. No, each of us -- Mr. Sullivan, one of the investigators
5 was there as well. So since we don't record things, each one
6 of us takes notes, because eventually we are going to write
7 something. So we are each writing notes, trying to recall what
8 was just said. So each of us took notes.

9 Q. I see.

10 At some point after the interviews were concluded, was
11 a report prepared?

12 A. Yes. We write something called an ROI, which is a review
13 of investigation.

14 Q. Who prepared that?

15 A. Myself and Mr. Sullivan, the two of us. He is an
16 investigator in Albany.

17 Q. Have you had the chance to look at the report of interview
18 that was generated in this case regarding Dr. Cameron?

19 A. Yes.

20 Q. Does it accurately record what took place during the
21 interview?

22 A. Yes.

23 Q. Do you stand by what it says?

24 A. Yes.

25 Q. Now, I think by now you know that Dr. Cameron has claimed

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Meyers - Direct

1 that the report was fraught with fabrications, bias, and
2 knowingly false statements, and I am taking that from his
3 complaint, paragraph 2005, and his affidavit at paragraph 51.

4 Are those claims true?

5 A. No.

6 Q. He also claims that you were belligerent during the
7 interview and that you substituted your own opinions and
8 answers to your own questions. He makes that claim in
9 paragraph 55 of his affidavit.

10 Are those claims true?

11 A. No.

12 Q. Do you have any idea why he might be making those claims?

13 A. Well, what I did in the interview, as we do in all the
14 interviews, is ask a question: Did you do a history? Did you
15 do a physical? Did you do a differential diagnosis? Maybe he
16 took that as belligerent if I asked it for nine different
17 patients. And then if I asked, Did you do a lab test? Did you
18 not do a lab test? So I tried to record basically everything
19 he said.

20 I never, to the best of my knowledge, ever criticized
21 any of the statements he made. I may have said, You treated
22 for four months? He said yes. I didn't say, You shouldn't
23 have treated for four months. You shouldn't have treated for
24 two years. I don't think I ever said that. I just recorded
25 what he said and what I said.

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Meyers - Direct

1 Q. He also claims that you falsely reported that he agreed
2 that there was no sign of Lyme disease in some of the patients
3 at certain times and that you flagrantly substituted your own
4 impression of multiple sclerosis?

5 A. I have no recollection of that. I don't think I ever did
6 that.

7 Q. What were you looking for when you were doing this
8 interview?

9 A. Well, this is a chance for him to tell a story. Remember,
10 someone has made a complaint. Most of the complaints we
11 realize, you know, there are two sides to every story, and this
12 is the chance for the doctor to tell his story. So what we
13 want to hear is how did he take care of this patient? That was
14 the bottom line. That's what we wanted to hear.

15 Q. I see.

16 He has also claimed that there is this grand
17 conspiracy among the defendants to eradicate from the
18 profession doctors that use a certain modality for treating
19 Lyme disease. Are you aware of such a conspiracy?

20 A. No, and I'm not part of it if there is one.

21 Q. I will ask you one more time, do you stand by what was
22 recorded --

23 A. Yes, I do.

24 Q. -- in your report and interview?

25 A. Yes.

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Meyers - Cross

1 Q. Do you have any hidden agenda against Dr. Cameron?

2 A. No, no, no, not at all, not at all.

3 MR. HERSHLER: Thank you, Doctor. I have no further
4 questions.

5 THE COURT: Okay.

6 All right. Mr. Simon, you may examine.

7 CROSS EXAMINATION

8 BY MR. SIMON:

9 Q. Dr. Meyers, good morning. I am shorter, so I am going to
10 bring --

11 A. Pardon?

12 Q. I am shorter than counsel, so I am going to bring the
13 microphone closer to me.

14 In 2010, Doctor, there were two interviews that you
15 had with Dr. Cameron, correct?

16 A. Yes.

17 Q. One was on about September of 2010, would you agree with
18 me?

19 A. Yes.

20 Q. And one was on about December 2010, correct?

21 A. Yes.

22 Q. And the reason why there are two interviews is because
23 there were several patients that the OPMC was examining
24 Dr. Cameron with respect to. You couldn't finish the interview
25 on the first time?

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Meyers - Cross

1 A. Yes, that's right.

2 Q. In 2010, what was your position with OPMC?

3 A. I was medical coordinator.

4 Q. As medical coordinator, what were your duties?

5 A. As I said before, to read over -- investigate a complaint,
6 let's say, someone made a complaint; and to, then, if it was
7 against a doctor or a hospital, we would ask to review the
8 records; and after we reviewed the records, if it was
9 determined that a patient -- a physician or a hospital should
10 have an interview, an interview was given and, as I said
11 before, to have the doctor tell the story of a patient or
12 multiple patients.

13 Q. In 2010, between -- in 2010, in the year 2010, do you
14 recall -- obviously Dr. Cameron was not your only interview,
15 correct?

16 A. I didn't --

17 Q. Dr. Cameron was not the only interview you conducted in
18 2010.

19 A. Correct.

20 Q. How many interviews did you have in 2010?

21 A. Probably 12 maybe, one a month, or 18. I don't recall
22 exactly.

23 Q. And from 2010 until the present, how many interviews did
24 you have?

25 A. Probably the same amount, you know.

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Meyers - Cross

1 Q. Is it your contention as we sit here today that the facts
2 pertaining to Dr. Cameron's interviews stick to your mind
3 independently in the matter that you testified to here today?

4 A. No. I reviewed materials, okay?

5 Q. So in preparation for this hearing, you reviewed -- what
6 did you review? The report of investigation?

7 A. No. This Exhibit F was given to me by the attorney.

8 Q. Exhibit F was Dr. Cameron's affidavit --

9 MR. HERSHLER: Objection, your Honor.

10 Q. -- correct?

11 MR. HERSHLER: Objection.

12 Q. Can you -- withdrawn.

13 What was Exhibit F?

14 A. It was also the ROIs that were written.

15 Q. So you reviewed the ROIs, correct?

16 A. Yes.

17 Q. And the ROIs are what you have written, correct?

18 A. With Mr. Sullivan, the two of us.

19 Q. And it is your understanding that, as the medical director
20 or the medical coordinator, you should have no input into the
21 ROI as to what your views are.

22 A. I am not the medical director.

23 Q. I'm sorry, the medical coordinator.

24 A. Medical coordinator.

25 Q. The question still stands, sir.

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Meyers - Cross

1 A. Could you repeat it, then?

2 Q. Yes.

3 Is it your view that, as the medical coordinator, you
4 should have no input as to what your personal views are towards
5 a certain diagnostic modality or treatment modality? You
6 should not infuse your personal views into the report of
7 investigation? Is that your understanding?

8 A. No, no, you can certainly ask questions based on what you
9 think my personal views are, or what -- the medical community
10 and science community or what's in the literature. You can
11 certainly ask questions.

12 Q. But it's not your function to give the answers also,
13 correct, sir?

14 A. Correct.

15 Q. And it is certainly not your function to insert into the
16 report of investigation your own views on what should or should
17 not be, correct?

18 A. Correct.

19 Q. An interview, a statutory interview, you will agree with
20 me, is just like you described it, an opportunity for
21 Dr. Cameron to discuss with you the issues of concern to the
22 OPMC, correct?

23 A. Yes, but we can respond by asking him questions about what
24 he means by that.

25 Q. But not by stating what your views are with respect to what

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Meyers - Cross

1 a particular medical modality should be with respect to a
2 particular patient.

3 A. You can say them, but it doesn't mean that you disagree
4 with what he says.

5 Q. Let's discuss this. As you are a member of the Infectious
6 Disease Society of America.

7 A. Yes, I was.

8 Q. At the time.

9 A. Yes.

10 Q. You are not a member anymore?

11 A. I haven't paid the dues yet.

12 Q. In 2010, were you a member of the Infectious Disease
13 Society of America?

14 A. Yes.

15 Q. Are you familiar with their guidelines for the treatment
16 and diagnosis of Lyme, sir?

17 A. Somewhat, yes.

18 Q. And you agree with those guidelines, correct?

19 A. Yes.

20 Q. And in the treatment --

21 A. They are just guidelines.

22 Q. Correct.

23 And in your treatment, you said that you treated
24 certain patients in a hospital setting?

25 A. No, no, I didn't say that. Well, what I meant is they were

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Meyers - Cross

1 seen and there was possibly a diagnosis was considered, a
2 differential diagnosis was considered. I don't personally
3 think I ever treated anyone with Lyme disease myself
4 personally.

5 Q. So is it your view, as we sit at the trial, was it your
6 view at the time when you interviewed Dr. Cameron that any
7 antibiotic treatment past a 28-day period is not established
8 appropriate or scientifically based?

9 A. No.

10 Q. It is not?

11 A. The view -- I said that was the view -- I either said the
12 CDC or the infectious disease guidelines. I never said
13 Dr. Meyers thinks this is what you should do and if you don't
14 do it you are wrong. If you review the record, I never said
15 that.

16 Q. Please state for the record what is your understanding of
17 the diagnosis of Lyme disease?

18 THE COURT: Could I pause for just a moment?

19 Do you know what, if any, the maximum period is under
20 the ILADS guidelines for treatment with antibiotics?

21 THE WITNESS: Me?

22 THE COURT: Yes. Do you know?

23 THE WITNESS: No.

24 BY MR. SIMON:

25 Q. Are you familiar with the ILADS guidelines?

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Meyers - Cross

1 A. No.

2 Q. Do you recognize the ILADS guidelines?

3 A. It isn't I don't recognize them; I haven't read them.

4 Q. I didn't finish the question --

5 A. Sorry.

6 Q. -- if it's okay.

7 A. Sorry.

8 MR. HERSHLER: Move to strike, your Honor.

9 THE COURT: No. I thought there was a question and
10 answer.

11 MR. SIMON: I can move on.

12 THE COURT: Go ahead.

13 BY MR. SIMON:

14 Q. You never read the ILADS guidelines?

15 A. No.

16 Q. You are aware that the Infectious Disease Society of
17 America of which you are a member disagrees with the guidelines
18 of the -- of ILADS?

19 A. I know they have their own guidelines. Since I haven't
20 read the other guidelines, I can't say whether they partially
21 agree or totally disagree. I only know the Infectious Disease
22 Society, so I don't know the answer.

23 Q. Did you ask Dr. Cameron during the interview whether or not
24 he practices pursuant -- he treats -- I'm sorry, withdrawn.

25 Did you ask Dr. Cameron during the interview whether

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Meyers - Cross

1 or not he practices medicine pursuant to IDSA guidelines or
2 ILADS guidelines?

3 A. No, I don't think I ever asked that.

4 Q. That was not of interest to you?

5 A. No. Because he told me when -- when he told me -- we went
6 through each patient -- how he treated them, I didn't say, Is
7 that part of any guidelines? I only said, I think, at one
8 point the Infectious Disease Society guidelines were bloop.

9 Q. You recognize as we sit here today --

10 THE COURT: I'm sorry. I didn't get it.

11 THE WITNESS: What I meant was, it's a whole long
12 thing, infectious disease guidelines.

13 THE COURT: I'm sorry. You said you think at one
14 point you said that the Infectious Disease Society guidelines
15 were what?

16 THE WITNESS: I meant they were -- there are a --

17 THE COURT: There are a lot of them.

18 THE WITNESS: Yes. That's when I said bloop, meaning
19 a lot of them.

20 BY MR. SIMON:

21 Q. Dr. Meyers, at the time when the interview took place,
22 before the interview takes place, the OPMC, the Office of
23 Professional Medical Conduct has to give Dr. Cameron notice of
24 what the issues are, correct?

25 A. Correct.

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Meyers - Cross

1 Q. In this case there were two notices in which what was
2 identified was solely his care and treatment of Lyme disease
3 and differential diagnosis?

4 A. No, no. My recollection it was for each patient.

5 Q. Correct. For each patient.

6 A. Care and treatment of. I don't think they said. I would
7 have to go back and look. Because each individual person was
8 different.

9 Q. Okay. But in the initiating letters, and there were two of
10 them, and I don't know if you recall them, the issues
11 identified was Dr. Cameron's treatment and diagnosis of Lyme
12 disease in each one of the patients listed.

13 A. I don't recall that.

14 Q. Would anything refresh your recollection?

15 (Pause)?

16 THE COURT: This is not a guessing game. Would the
17 letters that were actually sent help to refresh your
18 recollection as --

19 THE WITNESS: Sure.

20 THE COURT: -- to what was said?

21 THE WITNESS: No, what was asked.

22 THE COURT: What the scope of the interview was
23 intended to be?

24 THE WITNESS: Yes.

25 THE COURT: Yes.

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Meyers - Cross

1 MR. SIMON: May I approach, your Honor, because I have
2 the letter electronically.

3 BY MR. SIMON:

4 Q. I show you one of the letters is the letter of August 17
5 which is -- appears on the exhibit list as Exhibit J2, and I am
6 going to show you that -- the scroll button is down here, and I
7 am going to bring you down to the relevant part so that we can
8 save time, and I am going to show you the issues under
9 investigation involve, and I am going to ask you to read that
10 to yourself. And when we are done let me know -- you can
11 scroll down with respect to every patient.

12 A. "Care you rendered to" --

13 Q. To yourself, Doctor?

14 A. Oh.

15 Q. So when you are done, you can let us know.

16 A. Which is the scroll button?

17 Q. Right here.

18 MR. SIMON: Permission to approach?

19 THE COURT: Yes.

20 (Pause)

21 A. Okay.

22 MR. SIMON: Your Honor, you had a question?

23 THE COURT: No. Go ahead.

24 BY MR. SIMON:

25 Q. There is another letter which is the continuation.

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Meyers - Cross

1 Remember we discussed the continuation of the interview, and
2 that would be -- I'm sorry, let me ask you a question. You
3 finished reading?

4 You agree with me, do you not, that the scope of the
5 interview, the issues which were identified in the August 17
6 letter were Dr. Cameron's diagnosis and treatment of several
7 patients -- I didn't finish the question.

8 A. I didn't answer.

9 Q. -- of several patients with respect to Lyme disease?

10 A. You are only telling half the story. The meeting -- I
11 don't have it in front of me but, as I recall, it said the care
12 and treatment of a patient, Lyme disease, but not limited to
13 the care and treatment of neck pain, dah, dah, dah, and Lyme
14 disease, but not limited to Lyme disease. In other words, it
15 was the -- I agree that Lyme disease was in there, but it was
16 also the care and treatment of all whatever some of those
17 complaints are.

18 Q. Well, you are aware of the statutory requirements that the
19 OPMC has to give specific notice to Dr. Cameron of the issues
20 being investigated as opposed to saying everything under the
21 sun is under investigation, are you not?

22 A. Yes. Well, I think these letters are drafted by the
23 investigator. I did see it back then. But it was not just for
24 Lyme disease. If you read some of them out loud, you will see
25 that they say other things.

H662camH

Meyers - Cross

1 Q. I am going to read with respect to the patients that the
2 letter talks, "the care you rendered to" and the name is,
3 should be redacted "specifically the appropriateness of the
4 care and treatment you rendered to the patient for Lyme disease
5 and complaints of neck pain," we have one.

6 And then, for the next patient, "Specifically the
7 appropriateness of the care you rendered to Patient Two,
8 February 2008 to March 2008 including but not limited to the
9 diagnosis of Lyme disease, your differential diagnosis and
10 treatment," and so on and so forth.

11 But the specific resounding theme here is the
12 treatment of Lyme disease, correct?

13 MR. HERSHLER: Objection, your Honor. The letter
14 speaks for itself.

15 THE COURT: Sustained.

16 MR. SIMON: Okay.

17 THE COURT: Sustained. The letters really do say what
18 they say. I never like the objection that it speaks for
19 itself, because letters really don't talk, but when the
20 examination is simply limited to, This is what the letter says,
21 isn't it, then whatever the letter says it says.

22 If you want to ask the witness what in his view that
23 encompassed, what "care and treatment" encompasses, what
24 "differential diagnosis and treatment" encompasses, those are
25 all fair questions. But just to read the letter is not very

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Meyers - Cross

1 helpful.

2 MR. SIMON: Okay. I am moving on.

3 BY MR. SIMON:

4 Q. After the completion of the interview, you said you and
5 Dr. Sullivan authored the ROI which is the report of
6 investigation, correct?

7 A. Mr. Sullivan.

8 Q. Mr. Sullivan, yes. I'm sorry. He is an investigator,
9 correct?

10 A. Yes.

11 Q. And you have reviewed that that's attached to Dr. Cameron's
12 affidavit, correct, to Exhibit F that you reviewed?

13 A. The ROIs, yes.

14 Q. And you input into that, correct?

15 A. (Nodding head).

16 Q. Do you have any reason to believe that the report does not
17 reflect what it is -- that the ROI is incorrect or inaccurate
18 in any respects?

19 A. No, I think it's accurate I said.

20 Q. Do you have any reason to believe that -- as we sit here
21 today, you don't remember whether or not there were inaccurate
22 statements put in there?

23 A. As we sit here today, I don't recall any. I mean, there
24 may be a spelling error, something like that.

25 Q. Then what happens in the process, after the doctor received

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Meyers - Cross

1 the ROI, is being given a second chance to respond, correct, to
2 the ROI?

3 A. Yes.

4 Q. And then do you see the response to the ROI, the
5 corrections that Dr. Cameron sent?

6 A. Normally. I don't recall if I saw these.

7 Q. And normally is the ROI corrected to reflect the
8 respondent's response?

9 A. It may or may not be. Or you can write another ROI or
10 something and say, what I wrote -- I stand by what I wrote, or
11 just leave it alone. I haven't always responded to corrections
12 or statements from other physicians.

13 Q. Okay. In this case was another ROI issued after
14 Dr. Cameron's counsel responded?

15 A. To the best of my recollection, no.

16 Q. Dr. Meyers, when you say that there is no sign of Lyme
17 disease, what do you consider the signs of Lyme disease to be?

18 A. I think I didn't say there is no signs of Lyme disease. I
19 asked were there any signs of infection. In other words, I
20 think I should explain the difference between symptoms and
21 signs.

22 A symptom is a complaint. I feel fatigued, I feel
23 weak.

24 A sign is when you find something. If you come in
25 complaining of, let's say, numbness or tingling, that's a

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Meyers - Cross

1 symptom. A sign would be you do a neurological exam and you
2 find out that there is, let's say, decreased reflexes or
3 decreased motor function.

4 So I always asked -- probably Dr. Cameron a lot,
5 because we had a lot of patients -- were there any signs of
6 disease, and when he said, They don't need a sign or the
7 symptoms were the equivalent of a sign, I just noted it. I
8 didn't say, No, you are wrong. I never said, No, you are
9 wrong. If you didn't do -- I said, Did you do a differential
10 diagnosis? And he said no, I just recorded no. And many times
11 he said I didn't or I thought it but I didn't write it. I
12 recall some of those. Did you do a history and a physical? Of
13 course. In other words, if someone had a complaint where you
14 might examine somebody, if someone has pain in the leg, you
15 think the doctor, any doctor might examine someone with pain in
16 the leg to see if there is a sign meaning pain in the leg.

17 So I never criticized him as far as I recall for
18 anything he said.

19 Q. And do you agree with me, Dr. Meyers, do you not, that Lyme
20 disease does not always manifest itself with pain in the leg?

21 A. Of course.

22 Q. So an examination for pain in the leg is not necessarily
23 appropriate in Lyme disease?

24 A. No, no, but I'm saying if a patient complained to
25 Dr. Cameron or anyone that they had pain in the leg, it would

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Meyers - Redirect

1 be appropriate for me to ask, Did you examine the leg? If
2 someone had tingling, okay, did you do a neurological?

3 Q. As an example. I see what you are saying.

4 A. Yes.

5 Q. It is not disease specific.

6 A. Correct.

7 MR. SIMON: I have no further questions.

8 THE COURT: Thank you.

9 MR. HERSHLER: I just have one or two redirect, your
10 Honor.

11 THE COURT: Sure. Go ahead.

12 REDIRECT EXAMINATION

13 BY MR. HERSHLER:

14 Q. Just to clarify something, Dr. Meyers, in your mind, was
15 the interview supposed to be limited just to Lyme disease
16 without considering any other possible illnesses or conditions?

17 A. No. As I thought I tried to point out, it was not limited
18 to Lyme disease. In fact, we thought we said that. But that's
19 why I asked about differential diagnoses in almost every single
20 case, because it is possible a patient didn't have Lyme
21 disease. In other words, a physician, you know, and probably
22 Dr. Cameron did, considers in his mind all of the possibilities
23 that may occur when someone has a symptom. And so it was not
24 limited to Lyme disease. It was limited to the care and
25 treatment of the patient.

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Nemerson - Direct

1 MR. HERSHLER: Thank you. No further questions.

2 THE COURT: All right. Thank you, Doctor. You may
3 step down.

4 (Witness excused)

5 MR. SPIEGELMAN: Your Honor, we would like to call
6 Mr. Nemerson to the stand.

7 ROY NEMERSON,

8 called as a witness by the defendants,

9 having been duly sworn, testified as follows:

10 THE COURT: You may examine.

11 DIRECT EXAMINATION

12 BY MR. SPIEGELMAN:

13 Q. Mr. Nemerson, where do you work?

14 A. I work for the New York State Health Department, Division
15 of Legal Affairs.

16 Q. And what is your position there?

17 A. I am a deputy counsel in the unit that deals with the
18 professional misconduct subject area.

19 Q. And did you swear to an affirmation in opposition to
20 plaintiff's motion for a preliminary injunction in this case?

21 A. I did.

22 Q. That affirmation and the exhibits to it are in the record.

23 About how many physicians are there in New York State
24 currently?

25 A. There are -- if I can draw a distinction, the number of

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Nemerson - Direct

1 licenses granted to physicians in New York is not a number I
2 know. Physicians may -- physicians retain their license until
3 death or until the health department takes away the license,
4 and I am unaware of what the count currently is on living
5 licensees. However, under state law, physicians are required
6 to register their license every two or three years, and
7 currently there are approximately 95,000 physicians who have
8 registered a license. Of those 95,000, approximately 75,000
9 list a New York State practice address with the state education
10 department, which is the licensing authority.

11 Q. Now, of those registered physicians listing an address of
12 New York State, is there any legal restriction on them from
13 treating Lyme disease?

14 A. No.

15 Q. You stated in your affirmation that the Office of
16 Professional Medical Conduct investigates physician misconduct.
17 Could you briefly describe what kind of records the Office of
18 Professional Medical Conduct, which I will abbreviate at OPMC,
19 keeps?

20 A. Certainly.

21 MR. SIMON: Objection, your Honor.

22 THE COURT: Overruled.

23 A. OPMC will open a file upon receipt of a complaint or a
24 report of possible misconduct. That is opened with regard to a
25 particular physician. The initial report of complaint is

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Nemerson - Direct

1 reviewed. It may or may not state facts that, if proven, would
2 be misconduct. If not, very little else will go into that
3 file.

4 If it is not so clear, an interview may be performed
5 with the complainant. That would be written up as a
6 memorandum. Medical records might be obtained with regard to
7 the patient whose care is being questioned. Those medical
8 records will be obtained and reviewed at least by an in-house
9 staff person. If there is a summary written of that review,
10 that would be in the file. If facts need to be tied down,
11 other witnesses may be interviewed. Those are written up and
12 maintained in the file.

13 In those cases where it does appear, for example, if
14 there has been substandard medicine practiced, an outside
15 expert will be consulted. His or her opinion will go into the
16 file.

17 At some point, in some cases, the licensee about whom
18 the complaint has been made will be interviewed. That
19 interview is written up and put in the file. That licensee is
20 free to add any additional submissions that he or she feels we
21 should have.

22 That material goes into the file.

23 Q. What, if any, records would OPMC keep on any given
24 physician in New York State on whether they treat Lyme disease?

25 A. There would be no such record, unless of course we are

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Nemerson - Direct

1 investigating an allegation of care of a patient with Lyme
2 disease, it would be obvious in that file from the physician
3 records or from the interview that Lyme disease was an issue or
4 a factor.

5 Q. Are you familiar with the OPMC investigation into
6 Dr. Cameron?

7 A. I am. I did not participate, but I have been involved in
8 the subsequent litigation and the currently pending charges are
9 issued by my office and signed by me.

10 Q. But have you reviewed the 2010 report of interview in this
11 case?

12 A. I have.

13 Q. Do you recall who was present at that interview?

14 A. Yes. The interview of Dr. Cameron was performed by
15 Dr. Meyers, who testified earlier today; by Patrick Sullivan,
16 who is a nurse investigator of long standing with OPMC;
17 Dr. Cameron was there; and Dr. Cameron's prior attorney,
18 William Wood, of Wood & Scher, which was for many, many years
19 the leading law firm for licensees under investigation by OPMC.

20 Q. And you are familiar with Mr. wood, I take it?

21 A. I am.

22 Q. Dr. Burt Meyers, who was present at the interview, what is
23 his role in the investigation?

24 A. Dr. Meyers is one of several medical coordinators is the
25 title given them by OPMC. His role is not a statutory one.

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Nemerson - Direct

1 Since our investigators, some are nurses, some are lay
2 investigators, there is a need to have some staff people who
3 understand medical terminology, some medical concepts, who may
4 in some cases be better or more conversant and able, therefore,
5 to discuss things with the licensee under investigation, with
6 an expert. Dr. Meyers plays that role. He will occasionally
7 educate my staff or lawyers, nonphysicians, to help them
8 understand the facts and opinions in a given case. Dr. Meyers
9 happens to be a contract employee.

10 Q. Is Dr. Meyers considered the medical expert in this case?

11 A. Although I'm sure he has plenty of expertise, no, he is not
12 the medical expert. In our process, in order for an
13 investigation to be presented to what's called an investigation
14 committee we need to consult, under the statute, a medical
15 expert. We have long interpreted that to mean an outside
16 medical expert, and that is the person who plays the ultimate
17 role in helping the director make his determinations and,
18 should we go to hearing, to testify.

19 Q. And who was the medical expert in this case? Do you know?

20 A. I do know his name. Dr. Sanders.

21 Q. Thank you.

22 Was an investigation committee convened in
23 Dr. Cameron's case?

24 A. Yes.

25 Q. Were you at the meeting where the investigation committee

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Nemerson - Direct

1 considered the case?

2 A. I was.

3 Q. And do you recall who was on that committee?

4 A. Yes. Mr. Madonia, a social worker; Dr. Sears, who is an
5 orthopedic surgeon that happened to be the chairman of the
6 board in those days; and Dr. Putterman, a pediatrician.

7 Q. As far as you know, do the two physicians on the
8 investigation committee specialize in Lyme disease treatment?

9 A. I have no reason to think they did.

10 Q. What documents does the investigation committee consider?

11 A. That investigation committee, as in all our investigation
12 committees, presented with a report of the investigation. By
13 2010, the statutes had been amended to quite clearly specify
14 what goes into those reports. It includes the initial
15 complaint or report or complaints or reports; it includes any
16 medical review; it includes any interview reports done; it
17 specifically includes the report of interview of the licensee
18 under investigation; it includes any submissions or corrections
19 or other types of submissions made by the target licensee prior
20 to the investigation committee. All those things were included
21 in this report.

22 Q. Dr. Cameron has asserted that the -- his response to the
23 ROI was not submitted to the investigation committee. Is that
24 true?

25 A. It is not.

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Nemerson - Direct

1 Q. I would like to refer to the statement of charges that is
2 in evidence as Plaintiff's Exhibit I1.

3 A. Do I need to have that in front of me?

4 Q. Not yet.

5 Do you remember signing the document?

6 A. I do.

7 Q. Who prepared it?

8 A. An associate counsel on my staff.

9 Q. Did you review it?

10 A. I did. Multiple times.

11 Q. What documents are typically considered when preparing a
12 statement of charges?

13 A. When a prosecutor -- which I no longer am, but once was --
14 receives a case file and instructions to draw charges, the
15 entire investigation report is reviewed, particularly our
16 expert opinion, particularly the submissions made by the
17 licensee to begin to learn the facts and medicine of the case.
18 The medical records will obviously at some point be reviewed;
19 but, because we are lawyers and not doctors, first we typically
20 review the medical opinions. Certainly our own outside expert,
21 our medical coordinator, if he has given us a memo and if the
22 licensee has submitted their version, which is sometimes the
23 case, that will be reviewed.

24 Q. Do you have a recollection of the factual allegations in
25 the statement of charges about Patient A?

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Nemerson - Direct

1 A. I do in a generic fashion.

2 Q. Do you recall some of the concerns about Dr. Cameron's
3 treatment of Patient A?

4 A. Yes, yes. And I believe they were similar to the other
5 patients and to things that I said in my affirmation,
6 specifically, the criticism that we are bringing and prepared
7 to prove, include a failure on multiple occasions to take an
8 adequate medical history and to note it, which is required;
9 failure to perform an adequate physical exam and report it.
10 These are standard for virtually every medical case we bring.
11 There was a failure in this and several of the cases to work up
12 a differential diagnosis, which I have come to learn over the
13 years means, when presented with a patient, a prudent physician
14 doesn't just pick a single diagnosis and work with it, he or
15 she considers what other potential diagnoses might also fit the
16 fact pattern, and then systematically reduces it to what is the
17 best, most likely diagnosis. That was not done, we allege, in
18 this case.

19 Q. Those concerns you just mentioned, are those unique to
20 physicians who treat Lyme disease?

21 A. Absolutely not.

22 Q. Have you been involved in other investigations and
23 prosecutions that have raised similar concerns?

24 A. Several hundred.

25 Q. And what types of physicians have been involved in those

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Nemerson - Direct

1 cases?

2 A. All kinds. Every specialty.

3 Q. And what were some of the charges that were brought against
4 those physicians?

5 A. By "charges" --

6 MR. SIMON: Objection, your Honor.

7 THE COURT: Sustained.

8 A. -- I take it you mean --

9 THE COURT: Sustained.

10 BY MR. SPIEGELMAN:

11 Q. Moving on to the committee hearing that is upcoming,
12 Dr. Cameron has received an expert medical report from
13 Dr. Sanders and has objected to it. Will Dr. Sanders testify
14 at the hearing?

15 A. He will.

16 Q. Will Dr. Cameron have the ability to contest that
17 testimony?

18 A. Several ways.

19 Q. How could he contest it?

20 THE COURT: I'm sorry. Dr. Cameron isn't required to
21 testify at the hearing, is he?

22 THE WITNESS: He is not.

23 THE COURT: Given the opportunity, but he is not
24 required to testify.

25 THE WITNESS: Yes, Judge.

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Nemerson - Direct

1 BY MR. SPIEGELMAN:

2 Q. How can Dr. Cameron counter any testimony from Dr. Sanders
3 at the hearing?

4 A. Our hearing procedure under the statute provides that the
5 department will put on its case, including the medical
6 expert --

7 MR. SIMON: Judge, I'm going to object and move to
8 strike. We do not contest that within the administrative
9 process we don't have a way of questioning the fundamental
10 basis of what goes on. That's not what this case is about. I
11 believe it is about --

12 THE COURT: Okay. Overruled.

13 Q. You can continue.

14 A. In the majority of cases, once the department finishes its
15 proof in chief, which in this case I believe will simply be the
16 introduction of medical records and the expert testimony, there
17 will be a respondent's case. But before we get there, after
18 Dr. Sanders testifies, Mr. Simon will have a full opportunity
19 to cross-examine that expert. After Mr. Simon is finished, the
20 hearing committee will typically also ask questions of the
21 expert. After that is concluded, if appropriate, there will be
22 redirect and recross until everybody has exhausted.

23 After the department's case is presented, the
24 respondent, called in our proceeding, will present his case.
25 The licensee may or may not testify. If he testifies, it may

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Nemerson - Direct

1 be only about facts, he may give his medical opinion. He will
2 also have the opportunity to present an expert witness other
3 than himself. In the typical cases, those experts will have
4 already reviewed the testimony of our expert and may give
5 testimony as to why they disagree with it. They may have
6 reviewed the medical charts in evidence and they will explain
7 why they feel it was adequate care and why it was not negligent
8 or incompetent, and then the department cross-examines and the
9 committee asks questions.

10 At the end of the hearing process, both parties make
11 oral and written submissions where, again, one has the
12 opportunity to pick apart the opposition's expert witness.
13 Those submissions all go to the hearing committee who then
14 deliberate.

15 Q. If Dr. Cameron chooses to call an expert witness, could
16 that expert testify about the ILADS guidelines?

17 A. Absolutely.

18 Q. If Dr. Cameron objects to whether his treatment of Patients
19 A through G have run afoul of a physician -- our case, that his
20 treatment of those patients have run afoul of a physician
21 standard of care, is that something that he can dispute at the
22 hearing?

23 A. That is exactly what's disputed at the hearing, and that's
24 exactly what our hearing will determine in the first instance.

25 Q. I would like to turn your attention to Public Health Law

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Nemerson - Direct

1 230(9-b). Are you familiar with that provision?

2 A. I am familiar with it. I don't have it committed to
3 memory.

4 Q. As best you can, what does section (9-b) say about whether
5 a hearing committee may find a physician guilty of misconduct
6 based solely on his or her use of an effective treatment
7 modality that is not universally accepted?

8 A. What that means in conjunction with the last clause of that
9 section, which says that all other standards -- all other -- I
10 think the word is requirements must be met, what that means is
11 that the mere fact that a particular physician is practicing a
12 modality, a philosophy, a diagnostic style that differs -- it
13 says is nonuniversally accepted, it typically comes up when it
14 differs from the mainstream, from the centers of distribution
15 of practitioners, that by itself is not misconduct. That was
16 not misconduct before that amendment was brought. We have 50,
17 51 definitions of professional misconduct. If a physician
18 practices specialty X or style X and there is no negligent
19 practice and no incompetent practice or none of the other 48
20 definitions of misconduct, that can't be charged as
21 professional misconduct, won't be charged as professional
22 misconduct. And if for some reason my office did charge it,
23 which it wouldn't, the hearing committee could not sustain
24 those charges. Simply practicing a modality outside the
25 universally accepted modalities is not misconduct.

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Nemerson - Cross

1 Q. But does it mean that a doctor using an alternative
2 treatment modality like ILADS could never legally be charged
3 with misconduct?

4 A. It does not mean that at all. The statute is not a shield.
5 It's not a magic protection that once you do something that is
6 out of the mainstream or not universally accepted, you can do
7 whatever you want. Still basic standards of prudence and
8 prudent medicine have to apply. And the statement of charges
9 reflects that.

10 MR. SPIEGELMAN: Thank you. That's all the questions
11 I have.

12 THE COURT: All right.

13 Mr. Simon.

14 CROSS EXAMINATION

15 BY MR. SIMON:

16 Q. Good morning, Mr. Nemerson.

17 A. Good morning, Mr. Simon.

18 Q. A couple of questions.

19 Did you have a chance to review Dr. Sanders'
20 curriculum vitae?

21 A. Very briefly.

22 Q. Are you familiar with the IDSA -- the fundamental
23 differences between IDSA guidelines in treatment and diagnosis
24 of Lyme and ILADS guidelines in treatment and diagnosis of
25 Lyme?

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Nemerson - Cross

1 A. I am in one sense, yes.

2 Q. Is Dr. Sanders an IDSA or an ILADS doctor?

3 A. I apologize. I lose track of the acronyms.

4 Q. I'm sorry. IDSA is Infectious Disease Society of America.

5 A. He is that.

6 Q. Okay. And I was wondering, sir, why, if Dr. Cameron tells
7 you that he practices by ILADS guidelines, is there not a
8 physician that is selected --

9 THE COURT: I'm sorry. You don't mean that.

10 MR. SIMON: Sorry?

11 THE COURT: You said why if -- I thought you meant
12 Dr. Sanders. I'm sorry. Go ahead.

13 MR. SIMON: I'm still asking about the OPMC selection
14 of Dr. Sanders in order to substantiate these charges.

15 THE COURT: Yes.

16 MR. SIMON: I am going to go backtrack a little bit.

17 BY MR. SIMON:

18 Q. It is your position, is it not, that Dr. Cameron is not
19 being prosecuted for practicing medicine by ILADS guidelines,
20 ILADS is the International Lyme and Associated Diseases
21 Society.

22 A. Dr. Cameron is being prosecuted for practicing medicine in
23 the manner he did.

24 Q. And not because he practices pursuant to ILADS guidelines,
25 correct?

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Nemerson - Cross

1 A. I'm not a medical expert but, to my understanding, one can
2 practice by general ILADS standards but do it prudently, doing
3 a full physical exam, doing a history, doing all the things we
4 are alleging were not done in this case.

5 Q. So if indeed Dr. Cameron, your contention is correct that
6 he is not getting prosecuted for practicing by ILADS
7 guidelines, then why did your office select Dr. Sanders as an
8 expert who only practices by IDSA guidelines?

9 A. Dr. Sanders is a board certified physician, quite skilled
10 in his field. He knows anatomy. He knows physical exams. He
11 knows how to take a history. He knows how a prudent physician
12 practices medicine. This case and his opinion is not focused
13 particularly on whether it is ILADS or the other standards, it
14 is whether an adequate physical was done, history, differential
15 diagnosis, follow-up, mitigation of errors, mitigation of
16 injury.

17 We choose our experts based upon their qualification
18 as experts, not as to whether or not they belong to the same
19 organization as the licensee under investigation.

20 Q. Agreed, but there is a fundamental -- agreed with what you
21 said regarding how you chose it.

22 However, when you are prosecuting somebody, for
23 example, for using long-term antibiotics past 28 days, is it
24 not important to find an expert who is familiar with that
25 particular modality rather than somebody who repudiates it?

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Nemerson - Cross

1 MR. SPIEGELMAN: Objection.

2 THE COURT: Overruled.

3 A. If that were in fact the charges we were bringing, I might
4 be able to answer that question. We are not charging the
5 licensee with using an antibiotic for 28 days. We are not
6 charging him with using that set of standards. I won't repeat
7 myself for a third time. The statement charges lays out quite
8 specifically what we intend to prove and, for that, Dr. Sanders
9 is an ideal expert.

10 Q. I understand what the charges lay out, but there is a big
11 discrepancy between what the charges lay out and the report
12 that was disclosed, Dr. Sanders' report that directly attacks
13 Dr. Cameron for not diagnosing Lyme disease pursuant to what's
14 known IDSA guidelines. And, indeed, I submit to you, if you
15 compare Dr. Sanders's report to Exhibit C to the verified
16 complaint, he follows to a T the IDSA guidelines. Do you not
17 agree?

18 A. I can't agree because I don't understand what you just
19 said.

20 Q. Okay. I will rephrase it.

21 A. Thank you.

22 Q. Does Dr. Sanders' report -- he has two reports, actually.
23 One is about Patient G, and he refers back to the general
24 report about Patients A and F. Do you remember those?

25 A. Not --

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Nemerson - Cross

1 Q. Would you like to see them?

2 A. No.

3 Q. You reviewed them in preparation for this hearing, correct?

4 A. I did.

5 Q. Okay. Did you compare his reports to what is annexed as
6 Exhibit C to the verified complaint, which are the IDSA
7 guidelines?

8 A. I did not compare his report to the guidelines. Are you
9 asking about the guidelines or about my charges?

10 Q. But yet that is the expert and the testimony that the
11 department is going to propound at the hearing, correct?

12 A. Dr. Sanders is expected to testify in support of the
13 charges that are pending.

14 Q. In accordance with his report.

15 A. One would expect him not to change his view.

16 Q. And you disagree with me that his report does not -- I'm
17 sorry, disagree with me that his report parallels almost word
18 by word the IDSA guidelines as opposed to the ILADS guidelines?

19 A. I don't know what it parrots, or parallels. I didn't quite
20 hear that. And although I did see in his report that there are
21 references to differing standards for the diagnosis and
22 treatment of Lyme disease, you will note that the charges,
23 which are also consistent with his expert opinion, do not run
24 afoul of that problem. They state what I have already said
25 they state. Those charges are drafted by an attorney skilled

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Nemerson - Cross

1 in this area of practice, familiar with the statutes, familiar
2 with the misconduct definitions, who is then educated by the
3 expert, who works with the expert to determine whether in fact
4 there is medical expertise to be brought to bear on the facts
5 we can prove to establish possible misconduct. That possible
6 misconduct is found in the statement of charges. So I don't
7 doubt, although I don't know, that Dr. Sanders probably
8 disagrees with long-term antibiotic care, he probably disagrees
9 with particular criteria that your client is using to diagnose.
10 Many people do. It is not particularly relevant because our
11 testimony will be eliciting framework of our charges and that
12 will go to the adequacy of the history, the advocacy of the
13 physical, the working up of a differential diagnosis, the
14 monitoring for side effects, and addressing the presence of
15 side effects, etc. So whether you are able to cross-examine
16 him based upon his current philosophy is up to you and the
17 administrative law judge, but the charges are the charges. His
18 testimony will, we expect, support that. The hearing committee
19 will decide.

20 Q. Let me ask you a question. In 2015, we discussed public
21 law 230(9-b). That's when that law came into effect, correct?

22 A. Yes.

23 Q. And from what I remember from your affirmation, the
24 committee that OK'ed Dr. Cameron's prosecution was convened
25 sometime in 2011, correct?

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Nemerson - Cross

1 A. The investigation committee specifically plays a single
2 role, which is to concur or to fail to concur in the director's
3 determination that a hearing is warranted. That proceeding
4 took place before the amendment, that is correct.

5 Q. Did a proceeding take place after the amendment?

6 A. It's what I just said.

7 Q. I'm sorry. Withdrawn.

8 Did another committee -- was another committee
9 convened after the amendment took place?

10 A. No. None is required.

11 Q. I'm sorry?

12 A. None is required and none was --

13 Q. I'm going to move to strike.

14 THE COURT: Overruled.

15 Q. So if the committee gives its consent to prosecute a
16 physician before a change in the law takes place -- and this is
17 a hypothetical -- and the change in the law does take place
18 which prohibits the prosecution of certain conduct, it is not
19 required that the committee be reconvened and be made aware of
20 that change in the law?

21 A. It depends on what law has changed and what the facts of
22 the case are.

23 Q. Now, Dr. Sanders speaks about the fact that you cannot
24 diagnosis Lyme disease in the absence of erythema migrans rash.
25 Do you recall that in the report?

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Nemerson - Cross

1 A. I'm not sure.

2 Q. Would you like to see the report?

3 A. I am willing to believe you that it is there.

4 Q. Is the diagnosis of Lyme by erythema migrans rash a
5 criteria of the Infectious Disease Society of America?

6 A. I gather that it is.

7 Q. Is that diagnosis also a -- is the diagnosis rejected or
8 accepted by ILADS?

9 A. I don't know.

10 Q. So if you prosecute somebody for diagnosing Lyme disease in
11 the absence of an EM -- I'm going to call it EM for short --
12 rash --

13 A. If I do that?

14 Q. Yes. Hold on. If you prosecute somebody for diagnosing
15 Lyme disease in the absence of an EM rash, when other
16 guidelines tell you that it is okay to diagnose somebody with
17 Lyme disease in the absence of EM rash, is that a good-faith
18 prosecution in your opinion?

19 A. Cases are not prosecuted based upon guidelines. They are
20 not prosecuted based upon particular criteria. They are based
21 upon a stepwise analysis of what a physician knew at a given
22 point in time, and whether the next thing that physician did
23 was or was not consistent with the behavior of a reasonably
24 prudent physician who is managing and mitigating risk. It may
25 in a given case have to do with one does procedure X in the

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Nemerson - Cross

1 absence of sign Y. I don't know. I'm not a physician. But if
2 we cannot work with an expert and learn why step by step the
3 decisions that were made were either incompetent or negligent,
4 then there is no case. Whether a particular standard or
5 particular scientific test or a particular x-ray is needed in a
6 particular fact pattern, it may well be. I'm not an expert in
7 this case. I can't tell you what changes would have been
8 necessary in Dr. Cameron's behavior that would have avoided a
9 hearing other than, once again, adequately taking a history,
10 physical, differential diagnosis, etc., etc. Nowhere in those
11 charges have we alleged you looked at the left knee, you should
12 have looked at the right knee.

13 Q. The charges, Mr. Nemerson?

14 A. Yes, sir.

15 Q. And in the expert's opinion that goes to support the
16 charges. You agree with me?

17 A. The expert's testimony will support the charges.

18 Q. Correct. And the expert's testimony, by administrative law
19 judge's order, has to be disclosed to us and the reports that
20 was disclosed -- that were disclosed to us were Dr. Sanders'
21 reports, yes?

22 A. I don't mean to pick nits, but what was disclosed to you
23 were the expert's written opinions given to us in the course of
24 the investigation. Obviously his testimony at hearing will
25 correlate with that. It is the same subject matter, it is the

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Nemerson - Cross

1 same expert. As we present the case, the questioning and the
2 answers we expect to address why each of the numbered charges
3 add up to negligent and incompetent practice. On your
4 cross-examination, you will ask whatever you want based upon
5 the prior statements of our expert in his opinion to us. We do
6 not offer a written prior opinion in our case in chief. We put
7 on a live testimony. You will cross-examine it.

8 Q. But in this case there was an administrative -- you are
9 familiar with the administrative order that told you, the
10 department, to disclose the expert's testimony seven days
11 before the hearing?

12 A. I know nothing of the sort. What we were told to disclose
13 and what we did disclose was not testimony. Testimony is what
14 I am doing now.

15 Q. But you said that the testimony is going to be consistent
16 to the report?

17 A. Will correlate with it, yes.

18 Q. And you also agree that if Dr. Cameron practices by ILADS
19 guidelines, that in and of itself is not subject to
20 prosecution. You said so.

21 A. It is not subject to prosecution unless he fails to take an
22 adequate history, etc., etc., etc.

23 Q. Okay. But the practice by ILADS guidelines, such as using
24 long-term antibiotics in the treatment of Lyme disease, is not
25 subject to prosecution, correct?

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Nemerson - Cross

1 A. To my knowledge that does not by itself create an undue
2 risk that would be negligence if properly performed, including
3 all of the "et ceteras" I recited before.

4 Q. And the diagnosis of Lyme disease, and I am just giving
5 examples, referring you to the Sanders' report, diagnosis of
6 Lyme disease in the absence of an erythema migrans rash is not
7 an improper procedure, correct?

8 MR. SPIEGELMAN: Objection.

9 Q. For which you would get prosecuted. I'm sorry.

10 THE COURT: I think that question was already asked,
11 but can you answer that.

12 THE WITNESS: I can't really, Judge. I don't know
13 that specific medicine, and those two facts, those two
14 occurrences need to be in a constellation of behavior. They
15 don't hit you in the street when getting off the bus. There is
16 a history. There is a physical. Those things all need to be
17 done. I can't tell you, because I'm not a medical expert, what
18 would need to be done. So if those are the only two facts I
19 had, could I draw a statement of charges? No. But that's not
20 a hypothetical that tracks any reality that I experienced.

21 MR. SIMON: I don't have any further questions.

22 THE COURT: All right. Anything further?

23 MR. SPIEGELMAN: No redirect, your Honor.

24 THE COURT: Okay. Thank you. You are excused. You
25 may step down.

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1 (Witness excused)

2 THE COURT: Anything further from the defendants?

3 MR. HERSHLER: No, your Honor. We just reserve the
4 right to cross plaintiff.

5 THE COURT: Okay. Plaintiff?

6 MR. SIMON: I call Dr. Cameron.

7 THE COURT: Okay.

8 DANIEL CAMERON,

9 called as a witness by the plaintiff,

10 having been duly sworn, testified as follows:

11
12 THE COURT: Mr. Simon, you may examine.

13 DIRECT EXAMINATION

14 BY MR. SIMON:

15 Q. Dr. Cameron, good morning. I would like to direct your
16 attention, first, to the Exhibit A, which is your CV.

17 MR. SIMON: May I approach, your Honor?

18 THE COURT: Yes.

19 Q. I would like to you briefly tell the court about the
20 background, starting with your education, with your expertise,
21 and publications.

22 So let's start, where did you go to medical school?

23 A. I went to medical school at the University of Minnesota,
24 and then I went to graduate school in the School of Public
25 Health and received an MPH in epidemiology at the University of

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Cameron - Direct

1 Minnesota.

2 Q. How long have you been practicing medicine?

3 A. Since approximately 1982.

4 Q. Have you been in private practice since then?

5 A. Well, I had finished residency for those three years at
6 Beth Israel Medical Center and Mt. Sinai. Then I was assistant
7 professor of medicine at New York Medical College for a year or
8 two. And then I have been in practice in Mount Kisco, New
9 York, for 30 years.

10 Q. Do you have -- for 30 years in Mount Kisco that's in
11 Westchester County?

12 A. Yes.

13 Q. Do you have any board certifications?

14 A. I have a board certification in internal medicine.

15 Q. As an internal medicine practitioner, can you explain to
16 the court what type of patients do you see?

17 A. I train with mostly adolescents and adults, so I have been
18 working in primary care for the last 30 years and also as an
19 attending. So for the first 20 years, I would routinely admit
20 people to Northern Westchester Hospital for admissions and
21 evaluation and treatment.

22 Q. What professional societies are you a member of?

23 A. I am a member of the AMA, and also a member of the
24 International Lyme and Associated Diseases Society, ILADS.

25 Q. Are you a member also of the IDSA?

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1 A. Yes.

2 Q. So you are a member of both, correct?

3 A. Yes.

4 Q. Did there come a time when you started treating Lyme
5 disease patients -- diagnosing and treating Lyme disease
6 patients?

7 A. Yeah, at the end of 1987, I had three people that had
8 unusual illnesses, and after working with them in primary care
9 for a while, it became clear that Lyme disease was a problem
10 for them.

11 Q. Please explain to me, how many patients with Lyme disease
12 have you seen since 1987?

13 A. I believe it's over 20,000 patients with Lyme disease in my
14 practice.

15 Q. And you are familiar with the guidelines for diagnosis and
16 treatment of both IDS and ILADS, correct?

17 A. I am familiar with both the IDSA and ILADS guidelines.

18 Q. Tell me, did you have any involvement with the ILADS
19 guidelines?

20 A. Yes. I was the author, the first author for both the 2004
21 ILADS guidelines and also I was the first author for the 2014
22 ILADS guidelines, and in both cases with a different group of
23 professionals I was working with as coauthors.

24 Q. When I say IDSA guidelines, they have several guidelines,
25 but I am talking about the guidelines specific to Lyme disease.

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1 Do you understand?

2 A. I am familiar with the IDSA guidelines. I am just author
3 of the ILADS guidelines, one of the authors.

4 Q. Can you please explain to the judge the fundamental -- I'm
5 sorry, withdrawn.

6 Are there any difference between the two guidelines?

7 A. Yes.

8 Q. Can you please give the judge the highlight of the
9 differences first of the diagnosis and then of the treatment of
10 Lyme with respect to the two divergent guidelines?

11 A. The IDSA guideline focused ostensibly on the two-tier
12 laboratory tests, where you have to have a positive ELISA, and
13 a positive confirmatory western blot test, and it will say that
14 most people will have that criteria. In terms of clinical
15 presentations, the IDSA guideline refers primarily to an EM
16 rash.

17 Q. EM rash stands for what?

18 A. Erythema migrans rash. It will also refer to a Bell's
19 palsy, which is a facial palsy, and encephalitis, sometimes a
20 heart block. There is -- you can have a swollen knee, which is
21 like a synovitis pattern, and some people have an arthritic
22 pattern. There is also an entity called encephalopathy, Lyme
23 encephalopathy that's mentioned. Those are the diagnostic
24 categories that make up the IDSA guidelines. In terms of --

25 Q. Dr. Cameron, I want to ask you, are those bright line

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1 categories, meaning, in the absence of those symptoms and
2 diagnosis -- in the absence of what it is that is of those
3 constituents, that there should be no diagnosis of Lyme?

4 A. I don't think they say in there that you can't have other
5 clinical presentations. They just took what they considered
6 like the CDC list, the list that's in the CDC surveillance
7 criteria and a couple other of the criteria that are in the
8 literature, but I don't believe it says that that is an
9 exhaustive list, and just it's a list that they picked and have
10 included in the IDSA guidelines.

11 Q. Dr. Cameron, the CDC surveillance criteria, can you please
12 tell the judge what that is?

13 A. The CDC realized that there is a broad range of clinical
14 presentations, but there is only several that seem to be
15 reasonable to start with to help identify the number of cases
16 there are in America, so they picked an EM rash in an area that
17 has a lot of ticks. The rash should be over two inches. They
18 looked at Bell's palsy, heart block, and arthritis and
19 encephalitis, and those are the -- what's typically in a case
20 report form, and then it is used for surveillance. They
21 have --

22 Q. What does that mean, for surveillance?

23 A. Surveillance is public health goal of keeping track of
24 cases and the growth of cases, where the cases are, and it's
25 not intended for a clinical diagnosis. In fact, in the

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1 morbidity weekly report, in other words morbidity and mortality
2 weekly report, they point out that it is not intended for a
3 clinical diagnosis.

4 Q. I am going to actually direct your attention to what is in
5 evidence right now, Exhibit I4, Doctor. CDC came with Lyme
6 case definitions, correct, in which they specified what you
7 said right now, the criteria for surveillance?

8 A. They tried to specify, so that they could do surveillance,
9 what size a rash would be and various criteria.

10 Q. Does the CDC contend that its surveillance criteria for
11 diagnosis and treatment of Lyme disease, do they say that it is
12 appropriate for the clinical diagnosis and treatment of Lyme
13 disease?

14 A. I think they point out that it is not intended for a
15 clinical diagnosis. There are doctors who will use it and say
16 they don't make the diagnostic criteria and they will cite the
17 CDC surveillance definition. But, in practice, it is the
18 surveillance definition doesn't include all of the other types
19 of clinical presentations that have been prescribed in the
20 literature and have been seen in practice.

21 Q. I am going to show you what's been in evidence right now as
22 Exhibit I4, which is the CDC surveillance criteria that was
23 developed from 1995. Then I believe there are other following
24 years. I am going to ask you to read the comment --

25 MR. SIMON: May I approach Judge?

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1 THE COURT: Yes.

2 Q. -- in I4 from the CDC that it contains in its surveillance
3 criteria on Exhibit I4, and you can read it out loud.

4 A. Okay. Under comments, "This surveillance case definition
5 was developed for national reporting of Lyme disease and is not
6 appropriate for clinical diagnosis" and they put "not" in
7 capital letters.

8 Q. And the IDSA took the CDC surveillance criteria and
9 incorporated it in its guidelines?

10 A. Yes, although they will sometimes talk about chronic-like
11 encephalopathy type issues and -- but it is unclear from that
12 document whether one should ever make a diagnosis of it. They
13 just discuss the entity.

14 Q. Let's talk about the flip of the ILADS guidelines in the
15 diagnosis of Lyme disease. What does that entail? Can you
16 tell the judge.

17 A. Well --

18 Q. Withdrawn.

19 How does that differ if at all from the IDSA
20 guidelines?

21 A. Well, the IDSA guidelines said that there is no evidence
22 that chronic Lyme diseases exist as a distinct diagnostic
23 entity, and that any symptoms that someone might have --

24 Q. You mean the ILADS guidelines?

25 A. Yeah, the -- no. IDSA says that chronic Lyme does not

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1 exist as a distinct diagnostic entity. They also point out
2 that any symptoms are nothing more --

3 THE COURT: I'm sorry. You are on the IDSA --

4 THE WITNESS: Yes. Sorry about that. I meant that
5 there were two other things that were in the IDSA that set up
6 my description of ILADS.

7 THE COURT: All right.

8 THE WITNESS: That's why the focus.

9 THE COURT: Go ahead.

10 A. The two extra things that were quite clear from IDSA are
11 that chronic Lyme disease does not exist as a distinct entity,
12 but that has been interpreted by most readers that it doesn't
13 exist. They also said that the chronic manifestations are
14 nothing more than the aches and pains of daily living, and
15 that -- so that is the IDSA.

16 Now, from an ILADS perspective is that there are a
17 growing number of other clinical manifestations, other findings
18 that are being described in literature, that are seen in
19 practice. There is a growing number of coinfections which are
20 different kinds of infections, like Babesia, in those ticks.
21 And so the complexity of the illness and practice is not
22 reflected in the IDSA guidelines. So the practice, I need to
23 have a guidelines that were reflective of all of the different
24 kinds of diagnoses that I see in practice, all the different
25 diagnoses that are seen in the literature, and I needed that

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1 type of organization to help guide me in my diagnosis and
2 treatment.

3 Q. The ILADS guidelines, are they scientifically published?

4 A. The ILADS guidelines were prepared by this professional
5 society that I am a member of, that I have been president of in
6 the past. This guideline -- and there are two of them -- the
7 most recent one was prepared using guidelines proposed by the
8 Institute of Medicine, the IOM, and those guidelines used the
9 state of the art way of assessing evidence.

10 THE COURT: I'm sorry the Institute of Medicine, what
11 is the Institute of Medicine?

12 THE WITNESS: The Institute of Medicine is a
13 governmental body that advises on a number of topics, but in
14 this case they are advising how does one prepare guidelines,
15 how does one have guidelines that reflect the evidence.

16 THE COURT: Is that part of the National Institutes of
17 Health?

18 MR. SIMON: It's part of the Department of Health,
19 Judge.

20 THE WITNESS: It's a U.S. government body that might
21 be independent, but they weigh in on a number of issues.

22 THE COURT: Okay.

23 A. In this case they were looking at what the standards should
24 be for evidence-based guidelines, and so the Institute of
25 Medicine thought that the best way is to give some guidance on

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1 how guidelines are prepared. So they used a grade system,
2 which is a formal way of looking at the strengths and
3 weaknesses of the evidence, and looking at the biases in the
4 evidence, and working through a process of coming up with
5 evidence-based guidelines. That set of guidelines was prepared
6 by the organization, it was sent to a journal, it was peer
7 reviewed by a journal, expert review of infectious diseases,
8 and it was published in a journal listed in *PubMed*, which is
9 the National Library of Medicine. And there is also another
10 governmental agency that looks at guidelines to see whether
11 guidelines are up to a certain standard, and that was listed in
12 a National Guideline Clearinghouse, and it's available in a
13 National Guideline Clearinghouse Web site, and it has been used
14 extensively and cited extensively.

15 Q. What is the National Guideline Clearinghouse?

16 A. The government, to try to get various views out of what are
17 the different guidelines, what guidelines are available, has
18 created what they call a quasi government organization; and, if
19 they feel that the guidelines meet the criteria that they --
20 for each disease, they will take applications, review the
21 guidelines, and if you meet the guidelines, they will accept
22 them and post them on their Web site.

23 Q. Is Lyme disease treated with antibiotics?

24 A. Yes.

25 Q. Can you explain to the judge what the difference in the

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1 treatment of Lyme disease is between the IDSA guidelines and
2 the ILADS guidelines?

3 A. The treatment with the IDSA is that you should not treat
4 more than four weeks, with only one exception: that if you
5 actually have arthritis, they advise an additional four weeks
6 of therapy. That's it.

7 Q. Okay. And you read Dr. Sanders' report --

8 THE COURT: And what does ILADS say?

9 THE WITNESS: ILADS says that one should use clinical
10 judgment; that one should weigh the risk and the benefits of
11 the disease, the treatment; one should use shared
12 decision-making, weighing the risks and benefits, let the
13 patient be aware of it. The ILADS guidelines does point out
14 that there are differences between the two different
15 organizations and there are differences in the guidelines,
16 differences in the recommendations. But ILADS, after using
17 grade, felt that the clinical judgment was important.

18 THE COURT: Would a course of antibiotic over ten
19 years be consistent with the ILADS guidelines?

20 THE WITNESS: Well, the ILADS guideline does not give
21 a specific number of years or time frame. They use, after 30
22 days, a reassessment. They also advise that, in addition to a
23 diagnosis of Lyme is that one can reconsider, reevaluate as one
24 goes along, in case another diagnosis emerges or some other
25 illness occurs. So they don't have an exact time frame.

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1 THE COURT: So ILADS wouldn't give a safe harbor to a
2 prescription of antibiotics after four weeks. It would depend
3 upon how the doctor, under all of the circumstances, was
4 treating the patient.

5 THE WITNESS: Yes.

6 THE COURT: So it would be possible, for example, that
7 if a doctor treated a patient for ten years with antibiotics,
8 that that would not be sanctioned by the ILADS guidelines.

9 THE WITNESS: Well, it gives clinical discretion to
10 the doctor, but it advises the doctor assess and reassess based
11 on the risk/benefit. So it doesn't give exactly ten years.
12 There are people that get better in 30 days and don't need
13 anything on reassessment, and there are people that, two years
14 later, they are still sick.

15 THE COURT: The ILADS guidelines don't deal with
16 prescribing narcotics for a patient, do they?

17 THE WITNESS: They don't give -- other than just
18 following the patient, taking care of their illness, it doesn't
19 give any guidelines as to how to manage pain.

20 THE COURT: There is nothing in the ILADS guidelines
21 one way or another as to what a prudent level of care for a
22 patient by treating with narcotics would be.

23 THE WITNESS: It focuses on the care of the patient
24 rather than -- and focusing a lot on the diagnosis and
25 treatment of tick-borne illnesses, but not explicit as to what

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1 to do with a wide range of symptoms and pain and fatigue and
2 other issues that that patient might have. That will have to
3 be based on the -- and that's why they stress that follow-up is
4 important, reassessment is important, weighing the risk and
5 benefits, taking probiotics, for example, to prevent diarrhea,
6 but reassessment is important.

7 THE COURT: Okay. Thank you.

8 BY MR. SIMON:

9 Q. Let's talk about the testing for Lyme disease. Is there a
10 difference between the ILADS guidelines in the testing of Lyme
11 disease and the IDSA guidelines in the testing and methodology
12 of Lyme disease?

13 A. Well, the IDSA expects the two-tier to be positive for Lyme
14 disease. The ILADS knows that sometimes it is positive and
15 sometimes it is negative, so that one will have to -- might get
16 a positive ELISA, borderline ELISA, but one can't rely on the
17 test to diagnose cases of Lyme disease.

18 Q. Are you familiar with the term zero negativity?

19 A. Yes.

20 Q. What is that?

21 A. Well, zero negative is when the test does not meet the
22 two-tiered criteria, although everybody has their own
23 definition of what negative tests are. The NIH had four
24 clinical trials, so one of the four trials was called a zero
25 negative trial. That means they had enrolled only patients in

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1 that trial that had a negative test. So they recognized that
2 that was an important group.

3 Q. So do patients with -- did you define the term "zero
4 negativity" as being zero negative to ELISA/western blot
5 testing?

6 A. Zero negative is -- they might still have some positive
7 serologies, so it is a broad category. Some have had positive
8 tests on some criteria, but that, given, as always, the concern
9 and practice of what's a false positive, what's a false
10 negative, is that instead of having it as an absolute criteria,
11 it is important to look back at the whole history. Anything
12 that comes up on a physical exam, anything that comes up over
13 time, the consultants, and it is the whole story rather than
14 just the test.

15 Q. There are any other differences between the two guidelines
16 that you didn't speak about today?

17 A. I think that is the crux of the guideline I can think of
18 right now.

19 Q. Twenty-something thousand patients that you have seen with
20 Lyme disease, have you diagnosed and treated them by ILADS or
21 IDSA guidelines?

22 A. I treat within ILADS guidelines. Although, I recognize
23 that some patients get better in 30 days quite easily, some
24 people have a -- meet the CDC's criteria. There are certainly
25 plenty of people with rashes that were available and treated in

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1 a timely manner that do well. So -- but ILADS guidelines gives
2 me the flexibility to and a range of treatment options, the
3 diagnostic options to take care of my patients.

4 Q. Are the ILADS guidelines considered conventional or
5 nonconventional by the IDSA group?

6 A. The ILADS guidelines are considered not conventional by the
7 IDSA guidelines.

8 Q. Let's talk about the IDSA group. Is the view that a breach
9 of the IDSA guidelines should be tolerated in the treatment and
10 diagnosis of Lyme?

11 A. They don't tolerate the ILADS guidelines.

12 Q. And what is the view of the IDSA group that should happen
13 when somebody does not practice by the IDSA guidelines in the
14 treatment and diagnosis of Lyme?

15 A. I have found that the IDSA guidelines and those that
16 support the IDSA guidelines are not supportive of doctors who
17 treat under the ILADS guidelines.

18 Q. In fact, Doctor, I am going to direct your attention to
19 Exhibit I5 -- I'm sorry -- yes, Exhibit I5, which are annexed
20 to the affidavit.

21 MR. SIMON: May I approach, Judge?

22 THE COURT: Yes.

23 BY MR. SIMON:

24 Q. Which, for identification, is an accepted manuscript, and I
25 am going to ask you to have a look at it. I am going to ask

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1 you if you are familiar with it.

2 A. I am familiar with this article.

3 Q. Okay. And can you summarize for the judge what that
4 article says.

5 A. Well, the title is called False and Misleading Information
6 about Lyme Disease, and there are three authors, Dr. Shapiro,
7 Dr. Baker, and Dr. Wormser, and it was the *American Journal of*
8 *Medicine*, which is a common journal for doctors to read, and it
9 was accepted January 12 of this year. It doesn't say exactly
10 when it was listed on *PubMed*.

11 The article itself was focusing on some of the
12 problems that the doctors have had in proving like sexual
13 transmission or proving a persistent infection, which there
14 are. It's very difficult in disease. It's very difficult to
15 document. It's very difficult. Even the sexual transmission
16 data is -- I'm not comfortable with. I don't think the data is
17 good enough for me to rely on. But the -- they decided that
18 anything that disagreed with the view, the IDSA view, was
19 considered like false or -- I mean fake tests, fake diagnoses,
20 fake treatments. So they are characterizing anything that I do
21 as fake.

22 There is also one other item that they threw in at the
23 end of -- you know, other than the appearance that anything I
24 do is fake and anything that ILADS does is fake, they also
25 threw in one other thing, which is that, at the end, is that

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1 politicians -- can I read it?

2 Q. Yes, please.

3 A. "Politicians are attempting to displace mainstream
4 physicians as diagnosticians in the complex world of Lyme
5 disease by passing legislation that encourages use of unproven
6 treatments and that requires health insurances to pay for
7 unsafe remedies with no documented benefit and well-documented
8 adverse effects. This makes it difficult for medical review
9 boards to safeguard public health by disciplining those who put
10 patients at risk."

11 Q. And what is your understanding of that last paragraph?

12 A. My understanding is that politicians who had passed this
13 particular bill to protect doctors who have unconventional
14 approaches, they disagreed with that law. Although they didn't
15 characterize it completely, because that law didn't say
16 anything to do with requiring payment, so they added that extra
17 thing. It only said that they should be allowed to have
18 unconventional treatment.

19 Q. Are you familiar with --

20 THE COURT: Hold on.

21 MR. SIMON: I'm sorry.

22 THE COURT: Does the article refer to the ILADS
23 guidelines at all?

24 THE WITNESS: No, they said that they are referring to
25 the types of things that ILADS does without naming it, the type

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1 of things that we do, and so that's why I said they are more
2 characterizing what we do without mentioning ILADS.

3 THE COURT: Does the article refer to the New York
4 Public Health Law?

5 THE WITNESS: No, but -- it doesn't specifically say
6 the public health law, but it does refer to the politicians,
7 that they are passing laws. And the first part of the sentence
8 does refer to the intent of the law and the language of the
9 law, but not specifically, they don't cite the law.

10 THE COURT: Are there laws in other states similar to
11 the New York Public Health Law 230(9-b).

12 THE WITNESS: There are several states that have
13 similar legislation. Rhode Island is one of them. That was
14 the first one. Connecticut has some similar legislation that
15 allows them treatment. So we are not the first.

16 THE COURT: Okay. Thank you.

17 BY MR. SIMON:

18 Q. Dr. Cameron, are you familiar with Patients A through G?

19 A. Yes.

20 Q. They were your patients, correct?

21 A. Yes.

22 Q. What did you treat these patients for? I'm sorry. First
23 of all, what did you diagnosis them for as a group?

24 A. Well, each of the patients was quite different, so they
25 typically had a broad range of diagnoses when they came in.

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1 Because I am in primary care, I am used to having more
2 complicated cases than what get evaluated in clinical trials.
3 Some of them have quite an extensive list of diagnoses that
4 were there on presentation or emerged over the years that I was
5 their doctor.

6 Q. Was there a primary diagnosis and treatment that you
7 rendered for these patients?

8 A. Well, they varied. Like one of the cases that I had taken
9 care of for over a decade, he had bronchitis initially, and
10 then later he had an infection of the leg called cellulitis,
11 which he received IV for, then he had recurrence. So it was 11
12 years before he was ever diagnosed with Lyme. And the Lyme was
13 discussed by one of the surgeons, but that he was never
14 diagnosed and treated for the Lyme for 11 years.

15 Q. Do you recall which patient that was, A or --

16 A. A. It is -- the last letter is EK I believe.

17 Q. Which one was it?

18 A. EK.

19 Q. Okay.

20 A. I don't know what letter it is.

21 Q. Did you treat all of the -- did you diagnosis all of the
22 patients, A through G, with Lyme disease at some point?

23 A. At some point they were all -- they all received a
24 diagnosis of Lyme at some point during their care.

25 Q. But that wasn't your initial diagnosis of them, correct?

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1 A. Well, at the beginning, sometimes there were a broad range
2 of diagnoses that were there in the beginning, but Lyme was one
3 of them.

4 Q. When you diagnosed Lyme disease in these patients, did you
5 diagnose it uniformly by ELISA/western blot positive testing?

6 A. No.

7 Q. Why not?

8 A. Well, I find that the ELISA and western blot, which is
9 called the two-tier system, only work for some patients some of
10 the time, and I would leave a lot of patients untreated and
11 undiagnosed if I relied solely on those tests.

12 Q. Did you have a chance to review the two reports from
13 Dr. Sanders?

14 A. Yes.

15 Q. And Dr. Sanders -- does Dr. Sanders -- one of his opinions
16 faults you for diagnosing Lyme disease in the absence of a
17 two-tier test, ELISA/western blot positive testing?

18 A. Yes.

19 Q. And is that IDSA or ILADS guidelines?

20 A. He is making those conclusions, it appears, from an IDSA
21 perspective.

22 Q. And the charges uniformly -- and you are familiar with the
23 statement of charges in this case, correct?

24 A. Yes.

25 Q. And they uniformly accuse you of making the wrong diagnosis

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1 and missing something else, correct?

2 A. Yes.

3 Q. And is it your understanding that that is based on
4 Dr. Sanders' opinion that there is no ELISA and western blot
5 zero positivity?

6 MR. HERSHLER: Objection, your Honor.

7 THE COURT: Sustained.

8 Q. You read the charges, right?

9 A. Yes.

10 Q. And you read Dr. Sanders' opinions, correct?

11 A. Yes.

12 Q. What is your understanding that you are being prosecuted
13 for.

14 A. My understanding is I am being prosecuted for the treatment
15 of -- diagnosis and treatment of Lyme disease.

16 Q. I wanted to point you, there came a time when you came
17 under investigation, correct?

18 A. Yes.

19 Q. And you heard Dr. Meyers testify as to the interview,
20 correct?

21 A. Yes.

22 Q. I want to approach the witness and I want to show you what
23 has been marked Exhibit J2, which is a letter from August 17,
24 2010, from the OPMC director to you. I am going to ask you to
25 have a look at it.

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1 A. Yes.

2 Q. Are you familiar with that letter?

3 A. Yes.

4 Q. That was a letter that the OPMC has sent you before the
5 first interview took place, correct?

6 A. Yes.

7 Q. And I believe it notices the first interview on September
8 13, 2010?

9 A. Yes.

10 Q. And from reading that letter, what was your understanding
11 that the issues under investigation were?

12 A. They repeatedly say what I already read, which was that
13 they were looking at the diagnosis of Lyme disease and
14 treatment of Lyme disease.

15 Q. There is another exhibit, which is Exhibit J3, which is a
16 letter from the OPMC of October 28, 2010. Doctor, I am going
17 to ask you to have a look at it.

18 A. Every one of those patients, Lyme disease was one of the
19 diagnoses, and they were asking for an evaluation of each of
20 these patients.

21 Q. What was your understanding, from that letter, that the
22 issues under review were for the second part of the interview?

23 A. They say it is through the differential diagnosis and a
24 treatment of Lyme disease and treatment.

25 Q. Differential diagnosis, what is that?

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1 A. In medicine, there is a variety of diagnoses that might
2 explain the symptoms and there is something we are well trained
3 on, I am experienced in, and so it is the -- it is trying to
4 address what the final diagnosis will be. I am in primary
5 care, so even if I have a diagnosis after extensive workup,
6 there is still a differential diagnosis that stays from the
7 beginning to the end of my care.

8 Q. Can you explain to the judge what is IDSA's position with
9 respect to differential diagnosis when it comes to Lyme, the
10 IDSA guidelines position?

11 A. My understanding of the IDSA guidelines is that if they
12 don't meet the surveillance case definition, if they don't meet
13 the two-tier serologic test definition, they don't have Lyme
14 disease.

15 Q. Did Patients A through G meet the two-tier serologic
16 definition?

17 A. Most of them did not.

18 Q. Did these patients get diagnosed by you with Lyme disease
19 in the absence of erythema migrans?

20 A. Lyme disease was certainly on the differential, but the way
21 I practice is that there is also a possibility of another
22 diagnosis. So as long as they are under my care, I am going to
23 be directing tests and directing specialists to get involved to
24 make sure I don't miss another diagnosis.

25 Q. The accusations that Dr. Sanders throughout his report

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1 makes is that the testings for Lyme came back negative in each
2 of the patients and yet you kept on treating them for Lyme
3 disease. Did you see that?

4 A. Yes.

5 Q. Is that an IDSA or ILADS approach?

6 A. That's an ILADS approach.

7 Q. I'm sorry. Dr. Sanders's view, is that --

8 A. His -- Dr. Sanders' interpretation was consistent with the
9 IDSA approach.

10 Q. And in the ILADS approach you diagnose these patients with
11 Lyme in the absence of two-tier ELISA/western blot. Is that
12 right?

13 A. Yes.

14 Q. That's considered nonconventional by IDSA standards,
15 correct?

16 A. Yes.

17 Q. Is it your understanding you should be prosecuted for using
18 nonconventional methodology of diagnosis of Lyme?

19 A. I should not be prosecuted for nonconventional treatment of
20 Lyme disease.

21 Q. How about --

22 THE COURT: Doctor, Patient B you treated from 1998
23 through 2008. There was eventually the result of a lumbar
24 puncture test which was negative for Lyme disease, but positive
25 for proteins that were consistent with the diagnosis of

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1 multiple sclerosis. Does that mean that the patient did not
2 have Lyme disease?

3 THE WITNESS: Well, the spinal tap is not very good
4 for Lyme disease. Only 10 percent, 1 out of 10 people have an
5 abnormal spinal test with Lyme. So she had been followed by a
6 neurologist at the same time. So there is always a chance that
7 there is a dual diagnosis, that there is Lyme and multiple
8 sclerosis. That's why I encouraged her to stay with the
9 neurologist.

10 The extra problem with multiple sclerosis and Lyme is
11 that there is always uncertainty as what is multiple sclerosis.
12 Even when you have an abnormal spinal tap, there seem to be
13 some oligoclonal bands and myelin basic proteins that show up
14 in both conditions. So as long as a patient is aware that
15 there is a possibility of two diagnoses, I feel that as long as
16 they are informed, as long as they have a neurologist
17 following, looking for when to treat, and I am following them,
18 then the differential is covered.

19 THE COURT: Was it your conclusion at the end, after
20 the ten years of treatment, that the patient did or did not
21 have Lyme disease?

22 THE WITNESS: I'm not sure if she had ten years of
23 treatment because she had been off for a while. She just came
24 back and said a neurologist was going to try multiple
25 sclerosis. But I didn't find out whether or not -- whether the

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1 differential including multiple sclerosis turned out to be
2 correct either. I just didn't have that extra information to,
3 you know -- they were treating, I documented, but I can't be
4 sure that it was multiple sclerosis, but the neurologist felt
5 they should treat.

6 THE COURT: But you say you can't be sure whether it
7 was multiple sclerosis. Can you be sure it was Lyme disease?

8 THE WITNESS: No, I can't be sure of Lyme either.
9 That's why I maintained some treatment for Lyme, follow up with
10 a neurologist, because the differential included both of the
11 diseases.

12 THE COURT: A moment ago I thought you said that you
13 were convinced that all of the patients at issue in the
14 statement of charges had Lyme disease?

15 THE WITNESS: Well, they ultimately were diagnosed
16 with Lyme, but the problem with practice since I am in primary
17 care is even if I was to mention Lyme and discuss Lyme, I'm
18 still following, because it might turn out that over time that
19 another diagnosis emerges.

20 THE COURT: So with respect to the seven patients at
21 issue, Lyme was a possible diagnosis, but you are not -- it was
22 one of the differential diagnoses in each of the cases, but you
23 don't know to a reasonable degree of medical certainty, as they
24 say, that each of the patients in fact had Lyme disease.

25 THE WITNESS: Well, each of the patients, and I'm glad

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1 I get to answer this and discuss it, because sometimes I don't
2 get the chance to get my thoughts out, so thanks, but some of
3 these patients in over the course of five to ten years, with
4 all the consultations that I would call in, would have
5 diagnoses including psychiatric diagnoses, substance abuse
6 diagnoses, back injuries, cellulitis. So I couldn't be sure
7 that Lyme was all or part of it. So the differential in
8 primary care saves lives. When they say there is no diagnosis,
9 no differential diagnosis is that -- in real practice is that
10 there is always a differential, and I am never satisfied with
11 just Lyme as the diagnosis.

12 So that's why the Sanders letter or statement only
13 reflected a couple of the diagnoses that he picked out of the
14 chart. Many of these patients had fairly complicated,
15 exhaustive, prolonged diagnostic evaluations, as was apparent
16 in some of those other exhibits, and never completely sure
17 except that Lyme was -- in some cases I might treat, but I am
18 always looking for the other diagnoses.

19 BY MR. SIMON:

20 Q. So when you say the Sanders' letter, you mean Sanders'
21 report?

22 A. The report which reviewed some of the charts and mentioned
23 some of the charts. You know, like, for example, the
24 psychiatric diagnosis on one patient from Rhode Island, it is
25 true, the person has psychiatric -- was seeing a psychologist,

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1 seeing a psychiatrist, getting treatment for it, some of those
2 treatments were changing. We had communications with them.
3 But, still, the difficulty he was having teaching was quite
4 different than what he had had before and that underneath the
5 differential of the psychiatric issues, a decision was made,
6 clinical judgment, Lyme was a part of the story.

7 THE COURT: So, Doctor, what was the basis for
8 continuing to prescribe narcotics for the patient who moved to
9 Florida whom you couldn't see or examine or know what the
10 effect of the narcotics would be, particularly with a past
11 history of narcotics abuse?

12 THE WITNESS: Well, one of the things that happens
13 when you look back at a chart, I didn't realize at the time how
14 complicated, how severe the Lyme part would be, and also the
15 back injuries that she had after the motor vehicle accidents.
16 So the first narcotic was done by somebody else. The first
17 antianxiety was by somebody else. So, in hindsight, I didn't
18 realize how complicated these patients can get. You know, like
19 almost every pain management person will say that there are
20 some cases in hindsight that they would have done differently
21 as they piece it together.

22 I didn't realize that I would get turned down for pain
23 management by an insurance company. So that was in the record
24 of denial for access to care. I didn't realize that she would
25 have a motor vehicle accident related to a subdural hematoma

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1 and that she would have multiple fractures or at least multiple
2 injuries in her spine; that in weighing the pain management --
3 at that time, you know, the pain management people were -- when
4 I go to conferences, were saying there is that complexity of
5 pain abuse versus pain management and that if you are weighing
6 it, is that it is a complicated -- they actually are that
7 suffering.

8 In hindsight, there weren't many controls at the time.
9 I made a calculated decision to restart after all of those
10 injuries. I didn't realize I would get denied by insurance.
11 I didn't realize that in Florida I would get -- she couldn't
12 get access to pain management, and so -- and I didn't realize
13 there was an act of God, which was a major hurricane in
14 Florida. So the only thing I had left, if I didn't have
15 insurance cooperation, didn't have pain management cooperation,
16 was to do a detox with taper medicines, and so that's why that
17 fall was trying to -- if all my other resources were gone, then
18 all I have got left is the detox and taper, and I tapered over
19 the next couple months.

20 But, in hindsight, did I do a good job?

21 THE COURT: Well, I'm not --

22 THE WITNESS: It was not a good job, but did I do --

23 THE COURT: I'm not, I'm not asking you that.

24 THE WITNESS: No, but it's -- I learned a lot in
25 reading it.

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1 THE COURT: The reason I asked that question is, it is
2 one of those things that seems as though -- and I am not here
3 to try what's before the hearing, but it is one of those things
4 that appears to be quite different from the differences between
5 the ILADS guidelines and the IDSA guidelines. It doesn't seem
6 to be covered even by the ILADS guidelines. And yet it is
7 plainly within the statement of charges for which you had begun
8 to give your explanation to the statement of charges, but it
9 appears to be unrelated to an ILADS/IDSA issue, doesn't it?

10 THE WITNESS: Well, the only thing it touches -- there
11 isn't much overlap -- is that the IDSA guidelines says it is
12 nothing more than aches and pains of daily living. The ILADS
13 guidelines goes extensively into how severe it is, how much
14 pain there is, how severe the fatigue is, anxiety, the
15 neuropsych issues. So that reflection of how severe it is is
16 what I have seen in practice. So it doesn't necessarily say
17 how you should manage pain, except that it acknowledges pain,
18 acknowledges that it is important. So that ILADS guidelines do
19 acknowledge how serious it is and that one should address it,
20 but not specifically what the mechanism should be.

21 THE COURT: Thank you.

22 BY MR. SIMON:

23 Q. Dr. Cameron, out of the seven patients, how many patients
24 did you treat for pain management? Just one?

25 A. Only one that I am aware of.

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1 Q. Okay. And I wanted to go back to the interview because you
2 heard Dr. Meyers testify as to the interview. Were you at both
3 interviews present personally?

4 A. Yes.

5 Q. And who else was there?

6 A. The nurse.

7 Q. Mr. Sullivan?

8 A. That's it.

9 Q. And Dr. Meyers was there?

10 A. Yes.

11 Q. And your past attorney was there, correct?

12 A. Yes.

13 Q. And there were two interviews, correct?

14 A. Yes.

15 Q. And do you recall how -- you heard Dr. Meyers testify here
16 as to the interviews, correct?

17 A. Yes.

18 Q. And you put in an affidavit and a verified complaint in
19 this action, correct?

20 A. Yes.

21 Q. And you put in your recollection of the interviews,
22 correct?

23 A. Yes.

24 Q. And you also put in your -- you also read what it is that
25 was said in the report of the interview that was subsequently

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1 generated, correct?

2 A. Yes.

3 Q. And do you stand by those statements in your affidavit?

4 A. Yes.

5 Q. Okay.

6 Can you please summarize to the judge your
7 recollection of how the interviews went.

8 A. Well, I have a different recollection of my ability to tell
9 the story as the doctor was referring to. You know, how do I
10 arrive at what is a differential? He would -- for example, his
11 characterization of the differential is that I should have a
12 paragraph in one section. He didn't say that in the ROI, but
13 it should be a specific paragraph related to a differential,
14 how can I have Lyme disease on the differential if they didn't
15 have a rash or they didn't have a positive test. So then --

16 Q. A positive test meaning?

17 A. Positive two-tier test.

18 Q. And when you say a rash, what do you mean by that?

19 A. An erythema migrans rash.

20 Q. Is that what Dr. Meyers said?

21 A. Yes.

22 Q. But that wasn't included in the written report?

23 A. I didn't feel that that was reflected. The differential
24 which would keep recurring, come up was not that I didn't have
25 a differential, but -- because clearly I did extensive

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1 laboratories reflecting whether it is rheumatologic issues,
2 thyroid, blood, anemia, diabetes. The number of consultants
3 was much higher and broader than is reflected in any of these
4 reports. All of those things is that I didn't seem to be
5 writing it in a fashion or in the narrative style that he was
6 using, but he wouldn't really be specific. He said it is not
7 written the right way. And despite any of my discussions on
8 the differential diagnosis, he just said that it wasn't there.
9 And I could never guess -- he kept asking over and over again,
10 and it just wasn't there, the style that he is looking for.

11 Q. Did you state that the disease, there is no signs of the
12 illness or the disease at any time to Dr. Meyers?

13 A. Well, every time I mentioned signs and symptoms, then I
14 would get a lecture on what a sign is, which I already know
15 because I am an epidemiologist and I am an internist, board
16 certified, is that so many of the findings in Lyme disease are
17 symptom-based. The poor memory, the poor concentration, the
18 fatigue, the lightheadedness, the poor mood, the paresthesias,
19 all of these types of things are symptoms. But he kept coming
20 back to he is looking for the certain signs, a rash -- an
21 erythema migrans rash, a swollen joint or Bell's palsy, and so
22 everything else I would bring, he would say that doesn't count.

23 Q. What are those signs, ILADS or IDSA guidelines?

24 A. I felt he kept using the IDSA guideline signs and anything
25 else I had to say, he said that, well, then he would go back in

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1 the definition of what a sign is, then he would say, well, none
2 of those things count because those aren't the signs. He
3 seemed to be focusing on the signs that the IDSA reflects.

4 Q. And what are those signs?

5 A. Erythema migrans rash, swollen knee, and Bell's palsy.

6 Q. We heard him today speak about signs and the difference
7 between signs and symptoms. Is that how he articulated it to
8 you?

9 A. Except that here he was rather straightforward and simple,
10 but he gave me a narrative in my case. As soon as I would
11 bring something up, I wouldn't be able to have a chance to
12 finish it. He would wait until he found a "no," and as soon as
13 I said, no, that's not a sign, it's a symptom, then the "no"
14 would show up -- it would show up in the ROI. And so it seemed
15 like whenever the "no" word would pop up, no matter what the
16 context was, he said that he would only put in his recall of
17 something, and there were certain -- when I would say "no" it's
18 not a sign.

19 Q. Do you feel -- and you saw the ROI, correct?

20 A. Yes.

21 Q. And you stated in your initial affidavit what the
22 discrepancies were with the ROI, correct?

23 A. Yes.

24 Q. And do you stand by those?

25 A. Yes.

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1 Q. Do you feel that the ROI accurately reflected the two
2 interviews?

3 A. I thought there was plenty of things in the ROI that, like
4 that I had concerns with; that I wasn't able to tell my story,
5 wasn't able to lay out my understanding of the patients, and so
6 that was not reflective. What was reflective was pretty
7 simplistic, looking for a "no," looking for something, some
8 simplistic narrative without all of the language in it and the
9 understanding as an internist that internists tend to be kind
10 of complicated in their answers.

11 Q. Do you feel that Dr. Meyers infused his own views into the
12 ROI?

13 A. I feel for some reason an ROI reflected his interpretation
14 of it, very concise. When he got a "no," he would grab it and
15 he would do something. And I just didn't think it reflected
16 the true discussion that should take place on this complicated
17 topic.

18 Q. Was the IDSA/ILADS view discussed during the interview?

19 A. Yeah, I would say I practice with ILADS, and that didn't
20 seem to get reflected very clearly in the ROI. It seemed like
21 it was always coming back to an unstated criteria, which is the
22 IDSA.

23 Q. The interview, when I say "the interview," there were two
24 parts of the interview. You remember that there was one in
25 September and one in December, correct?

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1 A. Yes.

2 Q. What was the reason that the interview was conducted in two
3 parts?

4 A. Well, these charts would often be like 400, 500, 600 pages
5 long, and so by the time you get to that many charts, it is
6 hard to reflect eight hours of discussion. So I felt that,
7 even though the ROI looks long, it doesn't reflect the range of
8 topics that we either talked about or I wasn't allowed to talk
9 about.

10 Q. So when Dr. Meyers stated today, you heard him, that the
11 interview was an opportunity for you to explained issues
12 identified in the letter, was that opportunity given to you
13 during the interview?

14 A. I didn't feel that I was able to discuss the case or the
15 mandate of being able to share my views were overshadowed by
16 his views.

17 Q. By and large, the subject matter covered during the two
18 interviews, what was it?

19 A. Well, on treatment, for example, is that the repeated
20 questions of how can I treat more than 30 days if they don't
21 have Lyme, so over and over again is how can I be treating more
22 than 30 days?

23 Q. And what view does that reflect?

24 A. That reflects my understanding of the IDSA view.

25 Q. Okay. And did the interview focus on anything else other

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1 than the treatment and diagnosis of Lyme or was that the
2 primary subject matter?

3 A. They were all Lyme patients or at least sometime during
4 their history they had had Lyme, so the focus of all of the
5 interviews was Lyme disease.

6 Q. You said that, along with Lyme disease, you treated these
7 patients for other matters, correct?

8 A. Yes.

9 Q. And those matters are, to your understanding, they are not
10 subject to -- are they the subject matter of Dr. Sanders'
11 report?

12 A. I don't think Dr. Sanders did much -- reflected any of the
13 broad range of diagnoses that were in the chart. They just
14 focus on just Lyme. I think the exception might have been that
15 why was I using Rifampin in somebody that was taking Valproic
16 acid; and, in that case, it was done in consultation with
17 psychiatrist, psychologist that he was seeing, and it was also
18 done where we were checking blood levels to ensure that there
19 were adequate blood levels. But Dr. Sanders did not reflect
20 the broad range, even for one example that there was some
21 characterization of this case with obesity with lap band
22 surgery, well, the problem there is that he didn't have obesity
23 and he didn't have diabetes, he didn't have heart disease,
24 didn't have atherosclerotic heart disease when I first saw him.
25 It was only over the course of 11 years and after two cases of

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1 cellulitis of his legs that he finally got diabetes with
2 hemoglobin A1C of 6.1, his cholesterol, his weight was up, we
3 stopped him smoking successfully, he was diagnosed, finally the
4 lap surgery was done. And then finally, after 11 years, he was
5 diagnosed with Lyme, and then not treated with diabetes, he was
6 treated with oral.

7 Q. Dr. Sanders in that case does not focus on the other
8 treatments other than Lyme, correct?

9 A. I think Dr. Sanders did more of a snapshot. He would take
10 a couple diagnoses of diabetes, for example, and lap band and
11 not reflect. And primary care is that people accumulate
12 illnesses over time; and if you just take a snapshot, you are
13 not reflecting the differential, the making diagnostic
14 assessments and reassessments over time. And he just said a
15 snapshot, this was the problem, why was I treating somebody for
16 Lyme who had obesity.

17 THE COURT: Mr. Simon, how much time do you have left?
18 You exceeded --

19 MR. SIMON: My time is up? Yes.

20 THE COURT: You have exceeded your time already.

21 MR. SIMON: Okay.

22 THE COURT: Go ahead.

23 MR. SIMON: I got two minutes. One minute?

24 THE COURT: Sure. Go ahead.

25 BY MR. SIMON:

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1 Q. Dr. Cameron, I have one question.

2 You put in an affidavit discussing Dr. Sanders'
3 reports, the supplemental affidavit that we submitted yesterday
4 and you discussed his reports, his CVs. Are you familiar with
5 that, sir?

6 A. Yes.

7 Q. And that is Exhibit M and Exhibit M1 through 3, correct?

8 A. Yes.

9 Q. Do you stand by those statements sir?

10 A. Yes.

11 Q. Okay. I exceeded my time, so I have to cut off.

12 MR. SIMON: Thank you, your Honor.

13 THE COURT: Okay. We will take two minutes, three
14 minutes.

15 (Recess)

16 MR. SIMON: Your Honor, am I permitted one more
17 question, just one?

18 THE COURT: Sure.

19 MR. SIMON: A clarification question.

20 BY MR. SIMON:

21 Q. Dr. Cameron, when Judge Koeltl asked you about you being
22 sure of the diagnosis of Lyme disease in certain patients along
23 with the other differentials, your answer was, you started to
24 talk about the differential, but the question was were you sure
25 about your diagnosis of Lyme disease. Can you please elaborate

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1 whether you are sure or not?

2 A. I have looked at these charts carefully, and every one of
3 them I'm comfortable with the diagnosis of Lyme. I treated for
4 Lyme. I was comfortable with the diagnosis for Lyme. So just
5 because I am an internist, I am always -- they are my patients,
6 but that, yeah, every one of these had Lyme disease.

7 Q. So your prior answer when you said that you were not sure
8 of the diagnosis of Lyme disease, can you please elucidate that
9 for us?

10 A. I was focusing on the differential and misunderstood the
11 question, so I'm sorry for misleading on whether I was
12 comfortable with the -- that they all had Lyme as a diagnosis
13 in my effort to discuss the differential.

14 MR. SIMON: Thank you, your Honor.

15 THE COURT: Okay.

16 Mr. Hershler.

17 MR. HERSHLER: Thank you, your Honor.

18 CROSS EXAMINATION

19 BY MR. HERSHLER:

20 Q. Good afternoon, Doctor.

21 A. Good afternoon.

22 Q. You have made some claims about the inadequacy of your
23 interview with Dr. Meyers. You said that he kept lecturing
24 you, he didn't allow you to respond, that your recollection of
25 what happened differs from what appeared in the report of the

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1 investigation.

2 You responded through your attorney to the report of
3 investigation, did you not?

4 A. Yes.

5 Q. Do you have a copy of Plaintiff's Exhibits J1 through J5?

6 MR. SIMON: I can pull them up.

7 Q. I can bring one and show it to you if you want.

8 MR. HERSHLER: May I approach, your Honor?

9 THE COURT: Yes.

10 BY MR. HERSHLER:

11 Q. I direct your attention to the final portion of this
12 exhibit.

13 MR. SIMON: Which one?

14 MR. HERSHLER: Exhibit 5, I believe.

15 Q. That's the letter dated February 3, 2011, from the law firm
16 Wood & Scher to the New York State Department of Health, signed
17 by William L. Wood, Jr.

18 Did you see this letter way back when in February of
19 2011?

20 A. I believe so.

21 Q. My question is, these complaints that you are now making
22 about your interview, how come we don't find them anywhere in
23 this letter?

24 A. I think that over time that putting together -- I didn't
25 realize how difficult the IDSA position was going to be and how

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1 difficult it was in being interviewed under the IDSA type of
2 statutes, and so when I looked at the ROI and that interview,
3 that's why I have a clear picture of why that interview did not
4 reflect my history, examinations, clinical judgment or
5 follow-up.

6 Q. Your license was on the line back then, was it not?

7 MR. SIMON: Objection.

8 THE COURT: Overruled.

9 A. I think it didn't feel at the time that this was going to
10 be on the line, I was going to be dealing with complicated Lyme
11 patients with a diagnosis of Lyme and they wanted to hear my
12 perspective, hear my understanding, and be able to present it.
13 It is only in hindsight that I realized that I wasn't able to
14 reflect my care of the patient.

15 Q. But you have claimed that Dr. Meyers was belligerent. That
16 was not apparent at the time? You needed to reflect on that
17 over the past five years?

18 A. Well, I think that it is always difficult to, you know,
19 when you try to be polite, courteous, friendly, you know,
20 realizing that, rather than trying to carefully communicate and
21 discuss cases, it would come this far, that they would take
22 action that would jeopardize my livelihood, that would
23 jeopardize my ability to practice unconventional medicine as
24 defined by ILADS, it has become clear that I have to be more
25 straightforward and explicit in my concerns about those

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1 interviews.

2 Q. Is there any mention of the ILADS or the IDSA guidelines in
3 that letter in your response to the report of the
4 investigation?

5 A. Well, at the outset reflection of trying to be
6 professional, you know, hoping that, through the ILADS
7 guidelines process, getting the 2014 published again, is that
8 the dialogue would take place that would not involve
9 jeopardizing my livelihood, jeopardizing patients who have
10 Lyme, jeopardizing other of my colleagues who treat Lyme under
11 ILADS guidelines; and, given the gravity of it, I felt that it
12 was better that I reflect the interview.

13 Q. Let me give you another example. Regarding Patient DG, you
14 claim that the report of the interview falsely reported that
15 you had agreed there was no sign of Lyme disease, and I am
16 taking that from your own affidavit at paragraph 98. You
17 further contend that Dr. Meyers flagrantly infused his own bias
18 into the report by substituting his own impression of multiple
19 sclerosis for that patient, and that's at paragraph 101. Yet
20 your responsive letter didn't say anything like that, anything
21 like that in responding. These are rather powerful and serious
22 allegations. It did not occur to you at that time to raise so
23 much as an eyebrow as to what happened?

24 A. I always find in medicine that trying to get a dialogue,
25 keep things going, to reflect ILADS' positions, is not to take

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1 a combative approach or a dismissive approach in
2 characterizing. But now that it is becoming clear that there
3 is a divide that's not getting solved, that I'm not and my
4 colleagues alike are not able to practice, even with the intent
5 of the legislation, that also the inability to practice under
6 the -- in New York under the current climate, it was clear that
7 I had to be more forthcoming in my ability to reflect the
8 interview.

9 Q. Is your recollection of the interview better now than it
10 was in February of 2011?

11 A. My recollection of it was quite good then. It just didn't
12 ask me to clarify the nature of the interview. I didn't
13 realize -- it is just as clear then as it is now. I am just
14 reflecting that I didn't get a chance to communicate the cases.
15 You know, I got to hear Dr. Meyers' positions, got to hear
16 Dr. Meyers' conclusions, got to see those in the ROI, some of
17 his impressions, but that clarity is there.

18 Q. But it didn't occur to you to put your side of the story
19 when you responded?

20 A. Well, I didn't -- wasn't sure what this goal of trying to
21 get something done with Lyme, whether it's IDSA or ILADS, it
22 just didn't work, so that's why I have to be clear now.

23 MR. SIMON: Judge, I also object because the statute
24 doesn't give a --

25 THE COURT: Overruled.

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1 Q. Doctor, in your complaint, at paragraph 6, you complain
2 that there are open and systematic efforts by the defendants to
3 limit Lyme disease to the IDSA guidelines and to eliminate the
4 use of the ILADS guidelines.

5 Aside from your own disciplinary case, what are those
6 efforts?

7 A. Well, I think they are what we talked about earlier, where
8 they make clear that they want to get on to the disciplinary
9 hearings and no more of this legislation that protects doctors
10 who treat unconventionally. Also, I frequently get the denials
11 by insurance companies for services for my Lyme patients and
12 they cite the IDSA guidelines.

13 Q. Are you saying the insurance companies are part of the
14 conspiracy as well?

15 A. I don't think they are part -- they are part of reflecting
16 the IDSA position. You characterize it as conspiracy.

17 Q. Isn't that your claim that there is a conspiracy to violate
18 antitrust laws?

19 A. Yes.

20 Q. You did refer to that article entitled False and Misleading
21 Information about Lyme Disease, and I have it in front of me.
22 It is my only copy, actually. I will show it to you in a
23 second. My eyes aren't so good. I really read this closely,
24 and I could not find anything in here that openly calls for the
25 prosecution of doctors not following IDSA guidelines. If I

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1 show this to you, can you point out to me where this calls for
2 the prosecution of doctors?

3 MR. HERSHLER: May I approach?

4 A. I started out the discussion by saying the two, the three
5 authors, Dr. Wormser, the third author, he is the first author
6 for the IDSA guidelines that were published in 2000. He is the
7 first author for the 2006 IDSA guidelines; and so when
8 Dr. Wormser characterizes, and he is one of the authors, that
9 this is fake, this is all fake, and calls upon the legislative
10 bodies, the politicians to stop these measures, that may not be
11 a mentioned IDSA but, given he is the voice and the authorship
12 for IDSA, it is pretty clear to the reader what his position
13 is.

14 Q. He closes this article saying, "The real shame in all of
15 this is that the time, attention, and resources that are being
16 misdirected could be better spent on research that is designed
17 to address, to understand, and to try to remedy the problems
18 that these patients have. By so doing, we might begin to
19 improve the lives of those who are genuinely and indisputably
20 suffering, not just from Lyme disease." Do you disagree with
21 that?

22 A. Yeah, I think it is pretty clear that Dr. Wormser's
23 conclusion in the guidelines that chronic Lyme doesn't exist,
24 that it is nothing more than aches and pains of daily living,
25 is not supported by the literature. The ILADS guidelines

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1 clearly lay out how severe the problems are, how people are
2 failing intravenous, they are failing oral therapy. And so
3 when he is not reflecting here that there is extensive
4 research, there is NIH support for the complexities of Lyme.
5 And so when he says it is a real shame that there isn't
6 attention, time, or resources, there are a lot of resources and
7 time and attention that reflect the severity of Lyme.

8 THE COURT: Doctor, the question before was, in your
9 complaint you say that this article "called on medical boards
10 to prosecute physicians, such as the plaintiff, who disagree
11 with the IDSA views and who provide competitive medical
12 services by standards other than those of the IDSA." So the
13 question is, is there anything in the article which calls on
14 medical boards to prosecute physicians?

15 THE WITNESS: Well, the sentence, "This makes it
16 difficult for the medical review boards to safeguard public
17 health by disciplining those who put patients at risk," and so
18 being in practice in New York for this many years and what I
19 have seen, what my colleagues have seen, they didn't put
20 exactly "those who follow ILADS standards," but that's the
21 appearance that I get from reading that sentence.

22 THE COURT: Okay. Thank you.

23 BY MR. HERSHLER:

24 Q. Doctor, would you agree that if the net result of the
25 statute passed by New York in 2015 is to immunize doctors who

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1 follow the ILADS guidelines from being prosecuted for any
2 misconduct would be a bad result?

3 A. Well, I think that it still -- there are safeguards in
4 there to treat unconventional for Lyme, but also to still have
5 the normal role of supervising doctors who treat in New York.
6 There are still safeguards there.

7 Q. Such as maintaining the standard of care, correct?

8 A. Well, the standard of care in this case, there is the IDSA
9 standard, but the unconventional approach in ILADS is some
10 people might characterize that as a standard also.

11 Q. Are you saying that these guidelines are not guidelines but
12 instead they reflect standards of care?

13 A. Well, they are guidelines, and I think Dr. Meyers earlier
14 said guidelines are guidelines, they help us in our practice of
15 medicine, and so that the standard of care is a different
16 definition, a broader definition. They are both guidelines.

17 Q. You have further claimed that members of the State Board
18 for Professional Medical Conduct are followers of the IDSA
19 group and are seeking to place ILADS physicians out of
20 business. Do you know which members of the State Board you are
21 talking about?

22 A. I find it is unclear who all the members are of the board
23 and who is picked by the state to represent them. I know that
24 they didn't pick -- at least I don't see that they picked
25 somebody comfortable and experienced in ILADS guidelines on the

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1 committee that set the charges, and it doesn't appear as if the
2 doctor they have selected as expert witness for the upcoming
3 hearings is an ILADS physician, so it is not clear that they
4 even have somebody that is familiar and experienced with
5 unconventional approach to Lyme disease.

6 Q. So are you saying only a doctor who is a follower of the
7 ILADS guidelines can properly sit on the committee that hears
8 your case?

9 A. No. I am reflecting that for me to practice unconventional
10 treatment of Lyme disease to be judged by the panel is -- seems
11 to interfere with due process, interferes with the intent of
12 the bill that was passed by the legislative body, and it
13 affects my ability to practice in New York.

14 Q. Is it your position that all members of IDSA share this
15 desire to drive the ILADS physicians out of business?

16 A. No. I'm sure there is diversity in the IDSA organization,
17 as there is in all physicians. It is just that in this
18 particular case, because New York has this process, this
19 statutory process of reviewing doctors, for some reason it
20 comes across as denying my ability to practice with
21 unconventional medicine which was the legislative attempt. It
22 also seems to be interfering with my ability to offer a
23 different approach for Lyme patients who are sick.

24 Q. Isn't your practice booming right now?

25 A. Well, I think it is -- all practices are busy because of

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1 how many Lyme patients there are out there, and also that the
2 Affordable Healthcare Act, I would think most physicians would
3 say that having patients have access to care is booming for
4 many physicians.

5 Q. You claim to have 20,000 Lyme disease patients.

6 MR. SIMON: Objection. That is not what he --

7 THE COURT: Yes, sustained.

8 You said that you treated in the course of your
9 practice 20,000 Lyme disease patients.

10 THE WITNESS: Yes.

11 BY MR. HERSHLER:

12 Q. How many Lyme disease patients do you currently have?

13 A. It's hard to tell, because most of them are better. The
14 reason I can fit patients in my practice is that a lot of
15 people get better in a reasonable length of time, four weeks,
16 six weeks, eight weeks. There is a lot of turnover, especially
17 if they realize they should get treated in a timely manner. So
18 because I have been around for 30 years, I have so many
19 patients who get better in a short period of time frame, that I
20 seem to have time for complicated cases.

21 Q. Can you give us an approximation of how many of your
22 patients are currently suffering from the disease?

23 A. It's hard to tell, you know, because they can't -- can't be
24 sure. I just know that I have enough time in my day to do
25 evaluations, treat them, follow them, doing my phone calls, and

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1 have a family.

2 Q. As a member of the IDSA organization, you would agree that
3 the mere fact that someone is a member of that organization
4 doesn't mean that they are trying to put the other modality out
5 of business.

6 A. Well, I think there is diversity in the IDSA community, but
7 my concern is that, given the responsibility that the state has
8 to review licenses and review these practices, is that that
9 particular position by IDSA and their guidelines has been
10 interfering with my ability to practice, interfering with my
11 ability to take care of patients with unconventional
12 approaches.

13 Q. Then why are you still a member of IDSA?

14 A. Well, as I said earlier, you know, I still have a dream or
15 goal that, as we pour on the research, as we pour on the
16 understanding of Lyme, that there will be more and more doctors
17 who will take on the complexities of Lyme. So rather than be
18 combative or at war or those things, I will try to be as
19 professional as I can. It is just in this case I ran into
20 the -- how can I participate in the dialogue that we need if
21 the state restricts my practice?

22 Q. Looking at the statement of charges in this case, I think
23 we have already been over this, so I don't believe I need to
24 show it to you, but it alleges basic acts of misconduct, such
25 as, failing to take and/or note an adequate history, failing to

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1 perform and/or note an appropriate physical examination,
2 failing to appropriately construct differential diagnosis,
3 failing to timely follow up when a patient develops possible
4 adverse reactions to therapy, inappropriately prescribing
5 narcotics and other medications, and failing to maintain
6 accurate medical records.

7 Would you agree that a doctor that doesn't do these
8 things should be brought up on misconduct charges?

9 A. Well, I think that whenever you micromanage a chart and
10 look back at a chart, I think that it is still important to ask
11 those kind of questions, but I think it is, when you drill
12 down, you are going to run into there is always something
13 somewhere on some chart that doctors can respectfully disagree
14 on.

15 Q. So are you saying that these charges can never be proven in
16 any case?

17 A. No, they are important in the practice of medicine. We are
18 just running into a situation where it is the interpretation by
19 this particular process doesn't give me a fair representation
20 of this type of unconventional treatment, and it has taken us
21 down a different path. Still those are all standards that I
22 maintain.

23 Q. Is there anything to stop you at the upcoming disciplinary
24 hearing from demonstrating that you are adhering to all of
25 those standards?

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1 A. Well, I think that my concern at the disciplinary hearing
2 is that it is a two-out-of-three vote based on a group of
3 doctors who are selected, but for some reason I am going to be
4 laying things out in due diligence but that I am not sure that
5 I have the ability to lay out if I am not -- if I don't get to
6 keep my license that I will be able to adequately reflect my
7 care, reflect my care and have the appeal afterwards. The
8 details I am not completely sure of, other than it is a set-up
9 I can't really characterize very well.

10 Q. It's not your position that the ILADS guidelines allow you
11 to do any of the things that are stated in the charges, such
12 as, not doing a history, or an appropriate physical, not
13 following up on adverse reactions, failing to keep medical
14 records. The ILADS guidelines don't allow a doctor to do that,
15 do they?

16 A. No.

17 Q. Similarly, the IDSA guidelines don't allow that either, do
18 they?

19 A. No.

20 Q. So would you not agree that if these charges are true that
21 misconduct has occurred irrespective of whatever treatment
22 modality you used?

23 A. My concern is that there seems to be an adherence to a
24 particular set of guidelines, the IDSA, and that the panel
25 reflects that the IDSA type approach, the consultant, Sanders,

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1 reflected that, and so therefore, with that reflection, my
2 history, my physical exam findings, my differential, my
3 following up with patients, following up will not -- I am not
4 comfortable that they will be adequately understood in that
5 context. So therefore I don't feel that I will have adequate
6 representation of how I practice, and therefore I will end up
7 running the risk that the statutes won't be met, I won't be
8 able to practice in New York, my patients won't have access to
9 alternative strategies.

10 Q. You don't know who is on the hearing panel, do you?

11 A. No. I know the consultant I think they picked to review
12 the case, which is I think Dr. Sanders, and I have seen his CV.
13 So, given that he is going to be presenting the state's side,
14 I'm not sure that's going to reflect my practice with
15 alternative approaches.

16 Q. You will have -- your attorney will have the opportunity to
17 cross-examine Dr. Sanders, will he not?

18 A. Yes.

19 Q. And you will have the opportunity to present direct
20 testimony and to present whatever physical evidence or medical
21 records you feel supports your treatment.

22 A. Yes.

23 Q. And if, at the end of the day, there should be a hearing
24 determination against you, you will have the opportunity for
25 administrative review, correct?

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1 A. Well, the administrative review process is pretty weak and
2 the options that I have -- so therefore, if the IDSA position
3 is the predominant position of the -- as I am being judged, and
4 I am being asked afterwards to -- if there is an adverse
5 determination it is that I don't see that I am going to be able
6 to have access to my rights as a doctor, access to my rights
7 with this legislation, or access to being able to practice in
8 the State of New York.

9 Q. Are you saying that you think the administrative review
10 board would sustain a finding of misconduct even if it was in
11 violation of the state law?

12 A. Say it again.

13 Q. If there is a finding in your case that you violated --
14 that you committed misconduct strictly because you used a
15 different treatment modality or used one that isn't universally
16 accepted, are you saying that you think the administrative
17 review board will sustain that misconduct finding?

18 MR. SIMON: Objection.

19 THE COURT: Overruled.

20 A. I think there is enough uncertainty in the process, there
21 is enough uncertainty in the players that are being asked to
22 judge this unconventional treatment that I am seeking today an
23 extra layer of protection that I don't feel I am going to have
24 as a doctor in New York.

25 Q. Can you point to any decision by the administrative review

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1 board or by any hearing committee of the State Board for
2 Professional Medical Conduct which has upheld a misconduct
3 finding contrary to the state law?

4 A. Well, I don't think necessarily that I have the experience
5 and knowledge to -- first of all, I don't have the information
6 or the experience to judge whether anything adverse took place
7 or any questions were raised, so I couldn't answer that.

8 Q. Let's say the ARB, or the Administrative Review Board,
9 makes a mistake. You can appeal, can you not?

10 A. I'm not sure that the appeal process allows very many
11 rights. I am not convinced I can practice comfortably because
12 I don't think the appeal would give me very many options. It
13 certainly doesn't give me the option to -- that I feel I need,
14 as a doctor, to practice.

15 Q. But you are not unfamiliar with article 78 proceedings.
16 Didn't you in fact bring one and, as a result, this case was
17 delayed by several years?

18 MR. SIMON: Objection.

19 THE COURT: Sustained.

20 Q. Would you at least concede that there are -- there is the
21 option of going to state court to challenge the final
22 determination in your case?

23 MR. SIMON: Objection.

24 THE COURT: We know the answer to that question. It
25 is yes. It's a matter of law. Move on.

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Cameron - Redirect

1 MR. HERSHLER: I have no further questions. Thank
2 you, Doctor.

3 THE COURT: All right. Anything further?

4 MR. SIMON: Redirect, Judge?

5 THE COURT: Yes. You have exhausted your time, but I
6 will allow you some questions.

7 REDIRECT EXAMINATION

8 BY MR. SIMON:

9 Q. Really quick, Dr. Cameron, you have seen the statement of
10 charges, correct?

11 A. Yes.

12 Q. I am going to read this charge: "Respondent treated the
13 patient inappropriately with an ongoing and escalating
14 antibiotic regimen without appropriate sequential physical
15 examinations and clinical reassessment for reconsideration of
16 any alternative diagnosis and/or treatment." What does that
17 statement mean to you? And this is regarding Patient D.

18 A. I regularly do physical examinations.

19 Q. What does the statement mean to you?

20 A. Oh. They are trying to, with that particular patient,
21 trying to take something from a patient and to see whether I
22 meet the statutes.

23 Q. And what does the statement "respondent treated the patient
24 inappropriately with an ongoing escalating antibiotic regimen"
25 mean to you?

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Cameron - Redirect

1 A. That means there is some judgment on the unconventional
2 treatment of Lyme disease the way it is written, the way it is
3 paraphrased, is that it already puts me in a negative stance.

4 Q. Does that invoke the IDSA, ILADS --

5 A. It's clearly an IDSA type of assessment overtly in that
6 particular statement.

7 Q. And when there is a charge that's resonating throughout all
8 patients, which reads, "The respondent ordered and/or
9 prescribed parenteral antibiotics without medical necessity."

10 Are you familiar with this charge?

11 A. Yes.

12 Q. And this resonates with respect to all patients, correct?

13 A. Yes.

14 Q. What does that mean to you?

15 A. Well, that means that is being judged based on the IDSA
16 position that four weeks of antibiotics is a limit, no more
17 than four weeks of antibiotics, and that is the -- that is the
18 impression that is given when they make that judgment.

19 Q. And what is an appropriate physical examination in the case
20 of a patient that has Lyme disease according to IDSA?

21 A. Well, I don't think the IDSA explicitly says how much
22 should be in a physical, but what they are looking for is a
23 erythema migrans rash, a Bell's palsy, and a swollen knee,
24 which, here, what I do in a physical is, if those are positive,
25 those are noted. Like in one of the patients, EK, they had

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Cameron - Redirect

1 rashes, it is just that the rash was cellulitis. The negative
2 physical exam findings, I do a physical, I just don't write the
3 negatives.

4 Q. Where there is a charge saying, "Respondent repeatedly
5 failed to perform and/or note an appropriate physical
6 examination in the context of these patients," what does that
7 mean to you that you stand accused of?

8 A. Well, I do the physical exam, but I only write down the
9 pertinent physical findings. And the pertinent physical
10 findings would be the erythema migrans rash, a Bell's palsy, or a
11 swollen knee.

12 Q. So that means to you that that was not included in your --

13 A. Well, no, the rest of the physical exam I complete on a
14 regular basis, I just don't write them down as often as I
15 should.

16 Q. I have one more question. You agree, do you not, that
17 there is no immunity that PHL 230(b-2) confers upon an ILADS
18 physician for the practice of medicine other than what's
19 nonconventional by ILADS guidelines?

20 A. Yes.

21 Q. In other words, for example, if there is a misdiagnosis or
22 if there is something other than the treatment of Lyme disease
23 by ILADS guidelines, there is no immunity for that, correct?

24 A. No. I am still responsible for my patient.

25 Q. Is it your understanding that you are being prosecuted

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1 here -- from reading the statement of charges and Dr. Sanders
2 report, is it your understanding that you are prosecuted here
3 for anything other than the diagnosis and treatment of Lyme
4 disease by ILADS guidelines?

5 A. I am being judged for my unconventional treatment of Lyme
6 disease.

7 Q. I'm sorry?

8 A. I'm being judged for my unconventional treatment of Lyme
9 disease.

10 Q. You mean you are being prosecuted?

11 A. Yeah, prosecuted.

12 MR. SIMON: All right. I have no further questions,
13 your Honor.

14 THE COURT: All right. Dr. Cameron, you are excused.
15 You may step down.

16 THE WITNESS: Thank you.

17 (Witness excused)

18 THE COURT: All right. Anything further from either
19 side?

20 MR. SIMON: Not by way of evidence.

21 MR. HERSHLER: No, your Honor.

22 THE COURT: No. All right. I am familiar with the
23 arguments. I am familiar with the record. If the parties want
24 to make any closing argument to me in favor or in opposition to
25 the preliminary injunction, they can.

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1 Mr. Simon.

2 MR. SIMON: If I may briefly, your Honor, and I want
3 to refocus this whole thing. It is really whether or not
4 Dr. Cameron is being prosecuted in derogation of PHL 230(b-2).
5 It is not how many physicians before him are prosecuted for
6 what he is doing. It is not statistics of the OPMC. It is
7 about him being prosecuted in derogation of 230(b-2), and I
8 respectfully submit that his affidavits, Dr. Sanders' reports
9 and the statement of charges, which is disguised other than
10 what it is that Dr. Sanders' report speaks about, clearly
11 demonstrate that Dr. Cameron here is being prosecuted in bad
12 faith, in derogation of 230(b-2), for practicing -- for
13 treating Patients A through G for Lyme disease under the ILADS
14 guidelines.

15 Now, if the OPMC wants to dress it up as anything else
16 and state in the charges whatever they want, that is fine,
17 which is what they did, but when it came to the meat of it and
18 they disclosed what this case was about by showing their hand
19 and showing what Dr. Sanders' opinions are about, it is quite
20 clear that this is a prosecution of IDSA -- what they consider
21 that it is conventional treatment by IDSA guidelines *vis-à-vis*
22 nonconventional treatment by ILADS guidelines.

23 Thank you.

24 THE COURT: You are not relying on any of your
25 antitrust allegations for purposes of the preliminary

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1 injunction?

2 MR. SIMON: Well, the antitrust allegation, I thought
3 that the reason for the preliminary injunction is we got to
4 get -- there are two preliminary injunction applications. One
5 of them had to do with the antitrust. One of them had to do
6 with bad faith. If I don't get past bad faith, which is the
7 exception to the *Younger* abstention, I don't believe that you
8 can hear anything else. There is a separate, there is a
9 separate allegation regarding antitrust, and I believe, from
10 what I -- from the law that I cited, that the facts, the
11 Supreme Court of the United States disfavors the dismissal of
12 antitrust lawsuits. Why? Because the facts of the actual
13 conspiracy is within the control of the defendants.

14 THE COURT: Wait a moment. Wait a moment.

15 In opposition to the motion for preliminary
16 injunction, the defendants argued, among other things, that
17 there are several reasons why the antitrust claims are unlikely
18 to have merit, including state actors, including *Noerr v.*
19 *Pennington*, all of which you didn't respond to at all.

20 MR. SIMON: Actually, I put it in in my initial
21 memorandum, Judge.

22 THE COURT: Yes, of course there is an initial memo,
23 there is an opposition, and then there is a reply. In the
24 reply, you don't mention the antitrust laws at all.

25 MR. SIMON: Correct, because I thought I covered it in

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1 the initial. I didn't want to repeat myself, and I thought I
2 covered in the initial memorandum.

3 THE COURT: No, actually you didn't, but over and
4 above that, what is the antitrust injury that occurs while the
5 hearing is going on? Dr. Cameron continues to practice
6 medicine. He is not restricted in any way. Competition is not
7 affected.

8 MR. SIMON: Right.

9 THE COURT: There is no effect on competition. What
10 is the irreparable injury from the alleged violation of the
11 antitrust laws while the hearing is going on?

12 MR. SIMON: Correct. I see it the way you do.

13 THE COURT: What is it?

14 MR. SIMON: The antitrust irreparable injury is if the
15 services get restricted, correct.

16 THE COURT: Which doesn't occur until after the
17 hearing.

18 MR. SIMON: Correct.

19 THE COURT: So the antitrust laws are not and cannot
20 be a basis for a preliminary injunction.

21 MR. SIMON: Right, correct.

22 THE COURT: Okay.

23 My next question is, with respect to the argument that
24 it is necessary to have a preliminary injunction in order to
25 prevent the alleged bad faith conduct of the hearing, you argue

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1 that the bad faith conduct of the hearing is a violation of due
2 process, right?

3 A. Yes.

4 THE COURT: And is that procedural due process,
5 violation of liberty or property without due process.

6 MR. SIMON: The case law -- I'm going to answer that.
7 The case law that I cited, which is *Shaw* and *Bishop*, mainly in
8 the Fifth Circuit, your Honor, because the Fifth Circuit dealt
9 with this particular issue while the Second Circuit has not yet
10 done that.

11 THE COURT: Okay.

12 MR. SIMON: It is, and then *Bishop* was specifically
13 within a disciplinary prosecutorial conduct is that one should
14 be free of bad-faith prosecution, period. They don't really
15 specify procedural or substantive or what it is, and both *Shaw*
16 and *Bishop*, and I believe there was the other case that I cited
17 also out of the Fifth Circuit, say subjecting one to bad-faith
18 prosecution is a violation of due process. They don't specify
19 exactly which one it is.

20 THE COURT: Okay. Thank you.

21 Defendant.

22 MR. HERSHLER: Thank you, your Honor.

23 I'm not going to address the antitrust side of this
24 case.

25 In order to get past *Younger* abstention and even get

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1 to the merits plaintiff has to show bad faith, basically has to
2 show that there is no legitimate basis for the state
3 prosecution. I submit he has failed to do that.

4 There clearly is a legitimate basis for the state's
5 charges. Nothing in the charges mentions the type of modality
6 that he uses or suggests that they are singling Dr. Cameron out
7 for his preference, for a particular type of modality. He is
8 accused of failing to meet the basic standards of medical
9 practice. You can certainly argue that they are wrong, that it
10 it's not true, that what he did meet the standards. That is
11 for the disciplinary hearing. But there certainly is enough
12 evidence in this case, in this file, to show that this
13 prosecution has a basis.

14 I don't think anyone will dispute that there are
15 controversies involving how to treat Lyme disease. It is a
16 hotbed of controversy. But, nonetheless, the state has to be
17 able to regulate the practice of medicine, to protect the
18 patients from negligent doctors, and that's what they have --
19 that's what their investigative report, that's what the report
20 of the interview indicates, that he has not been doing the
21 basic things that need to be done to take care of virtually any
22 patient. He has not been doing adequate physicals. He has not
23 been taking histories. He has not been following up. Instead
24 it appears that he has been putting his patients on long-term
25 antibiotics and he has been injuring them, and they may well

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1 have been suffering from other diseases besides Lyme disease,
2 such as multiple sclerosis.

3 I am not a doctor. I can't possibly decide who is
4 right in this case. That's up to the State Board after a
5 full-fledged hearing with expert testimony, all of the medical
6 records examined. There is nothing unusual about this case in
7 that respect. It needs to go forward after all these years.
8 There are many patients at stake here. If the doctor's
9 treatments are up to the standard of care, which is not ILADS
10 or IDSA, standard of care depends on each individual case,
11 based upon, as Mr. Nemerson said, a whole constellation of
12 evidence available in that case, if he meets the standard of
13 care, that's terrific. That means his patients are being
14 treated well. But if he is not, then the possible harm to his
15 patients, considering how many there are, although he doesn't
16 seem to know how many there are, is quite extreme, and I
17 believe that, if nothing else, the balance of equities in this
18 case falls heavily on the side of the state being able to
19 proceed with its case. And if something goes terribly wrong,
20 the hearing committee messes up, then the Administrative Review
21 Board somehow upholds misconduct charges, even though there is
22 a blatant violation of law, because all they were trying to do
23 was penalize him for using a methodology that's not universally
24 recommended, he has still judicial redress in the Appellate
25 Division, and he can go there and get an immediate stay before

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1 his license is touched in any way. And the Appellate Division
2 is not populated by doctors. It is populated by judges who
3 have no competitive interest in this matter at all.

4 I think the real problem here is that if this kind of
5 case, if this kind of injunction is sustained, it will throw a
6 real chilling effect into the state's ability to bring cases
7 where there are actual controversies over the method of
8 treatment, and that would be terrible. That would be contrary
9 to the interests of the public entirely.

10 There really isn't much else besides that. He hasn't
11 raised a constitutional claim. This circuit doesn't recognize
12 malicious prosecution in an administrative proceeding when
13 there has been no interference with a property right and there
14 hasn't been here. There is a summary suspension procedure
15 available. The commissioner did not invoke it. He is able to
16 practice until his disciplinary hearing is decided. There have
17 been other cases where the summary suspension procedure was
18 invoked and the courts have ruled on that. If you look at the
19 *DeBlasio* case, you can see what's discussed there. This is not
20 such a case. The constitutional due process right is you get a
21 hearing with notice prior to a deprivation of a right. That's
22 what he is getting. He is getting a full hearing. How can you
23 take what is actually the remedy for the requirement to give
24 due process and somehow distort that into a deprivation of due
25 process? He hasn't stated a constitutional claim and bad

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1 faith. I think that there is enough here, more than enough, to
2 show that the state is proceeding in good faith. They are just
3 trying to do their job, and I think the time has come for them
4 to be able to do it.

5 Thank you, your Honor.

6 THE COURT: Okay. I will take the matter under
7 submission. I appreciate that the hearing is scheduled for
8 Monday. I will have decided the case before Monday.

9 Thank you all.

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